

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2955
State File No.
0238
Registrar's No.

FILED JAN 28 1953

318

1003

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town OR TOWN) St. Louis, Mo		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis 2119	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital		d. STREET ADDRESS (If rural, give location) 4603 a. St. Ferdinand Ave	

3. NAME OF DECEASED (Type or Print) a. (First) Earnest b. (Middle) c. (Last) Cochran			4. DATE OF DEATH (Month) (Day) (Year) 1 7 1953			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH May 6, 1903	9. AGE (In years last birthday) 49	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Presser		10b. KIND OF BUSINESS OR INDUSTRY Silverman Cleaners		11. BIRTHPLACE (State or foreign country) Mariana, Arkansas		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Henry Cochran		13b. MOTHER'S MAIDEN NAME Maria McCary		14. NAME OF HUSBAND OR WIFE Tomoa Cochran	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) No None		16. SOCIAL SECURITY NO. 497-03-1250		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Tomora Cochran 4603 a. St. Ferdinand	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CEREBRAL HEMORRHAGE			INTERVAL BETWEEN ONSET AND DEATH 3 days
		ANTECEDENT CAUSES DUE TO (b) _____ DUE TO (c) _____			
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 331X	

22. I hereby certify that I attended the deceased from **Jan. 5, 1953**, to **Jan. 7, 1953** that I last saw the deceased alive on **Jan. 7, 1953**, and that death occurred at **9:30 P. M.**, from the causes and on the date stated above.

23a. SIGNATURE W. N. W. Colark M.D.		23b. ADDRESS 2748 A Franklin Ave		23c. DATE SIGNED 1-9-53	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 1/12/53		24c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery	
				24d. LOCATION (City, town, or county) (State) St. Louis County, Missouri	

DATE REC'D BY LOCAL REG JAN 9 1953		REGISTRAR'S SIGNATURE Charles Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS C. W. Roberts 1416 N. Taylor Ave.	
--	--	--	--	--	--

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., **Student Embalmer No.**

working under my personal supervision.

Student
Student Embalmer

Signed

Licensed Embalmer No.

P. O. Address

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.