

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14649

State File No. 20

FILED MAY 10 1954

BIRTH NO. _____ REG. DIST. NO. 381 PRIMARY REG. DIST. NO. 4375 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY SULLIVAN		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY SULLIVAN	
b. CITY (If outside corporate limits, write RURAL and give township) MILAN		c. CITY (If outside corporate limits, write RURAL and give township) MILAN	
d. FULL NAME OF HOSPITAL OR INSTITUTION SULLIVAN CO. MEM. HOSP.		d. STREET ADDRESS (If rural, give location) 1050	

3. NAME OF DECEASED (Type or Print) a. (First) ROBERT b. (Middle) EDWIN c. (Last) COCHRAN	4. DATE OF DEATH (Month) (Day) (Year) 4 26 1954
5. SEX MALE	6. COLOR OR RACE WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH 6/29/1884
9. AGE (In years last birthday) 69	IF UNDER 1 YEAR Months 9 Days 28
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMING	10b. KIND OF BUSINESS OR INDUSTRY MO
11. BIRTHPLACE (State or foreign country) MO	12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME JAMES H COCHRAN	13b. MOTHER'S MAIDEN NAME ELLEN CONNELL	14. NAME OF HUSBAND OR WIFE ANNA PEARL COCHRAN
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Kenneth E Cochran Milan

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		INTERVAL BETWEEN ONSET AND DEATH 3-25-54
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Dry Gangrene Left foot		6 yrs. 3-26-54 3-20-54
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) arteriosclerosis coronary thrombosis DUE TO (c) Pulmonary complications		
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 4201	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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?

22. I hereby certify that I attended the deceased from **3-26-54**, 19**54**, to **4-26-**, 19**54**, that I last saw the deceased alive on **4-26**, 19**54**, and that death occurred at **5:30 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Earl Drayton D.D.	23b. ADDRESS Milan, Mo	23c. DATE SIGNED 4-26-54
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4-28-54	24c. NAME OF CEMETERY OR CREMATORY SHATTO
24d. LOCATION (City, town, or county) (State) SULLIVAN MO	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Mrs. H. B. Harris Registrar's Funeral Service Milan	

DATE REC'D BY LOCAL REG. **May 1-1954**

(Licensed Embalmer's Statement on Reverse Side)

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

Russell L. [Signature]

Licensed Embalmer No. 3792

P. O. Address Melrose, Mo.

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.