

FILED APR 27 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 13211
2227

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission). a. STATE Mo b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis Mo		c. CITY OR TOWN Webster Groves	
c. LENGTH OF STAY (In this place)		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION 2331 Olive St		e. STREET ADDRESS (If rural, give location) 227 Old Watson Road	

3. NAME OF DECEASED (Type or Print) a. (First) Robert b. (Middle) M c. (Last) Cochran			4. DATE OF DEATH (Month) (Day) (Year) B 11 55		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH April 11, 1882		9. AGE (In years last birthday) 72		10. IF UNDER 1 YEAR Days 11 0	
11. BIRTHPLACE (City and State or Foreign Country) St Louis Mo		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Co Owner		10b. KIND OF BUSINESS OR INDUSTRY Academy Awning Co			

13a. FATHER'S NAME James Cochran		13b. MOTHER'S MAIDEN NAME Elizabeth Hamilton		14. NAME OF HUSBAND OR WIFE Frances Cochran	
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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. 191-36-0001		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs Frances Cochran 227 Old Watson Rd	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease		DUE TO (b) _____				7 yrs	
* This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		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 checked="" type="checkbox"/>	
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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) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 4200	

22. I hereby certify that I attended the deceased from 8-9, 1954, to 3-1, 1955, that I last saw the deceased alive on 2-1, 1955, and that death occurred at 7:30 A.M., from the causes and on the date stated above.

23a. SIGNATURE Paul O. Hagemann M.D.		23b. ADDRESS 3720 Washington		23c. DATE SIGNED 3-11-55	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 3-11-55		24c. NAME OF CEMETERY OR CREMATORY Calvary		24d. LOCATION (City, town, or county) (State) St Louis Mo	
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DATE REC'D BY LOCAL REG. MAR 12 1955		REGISTRAR'S SIGNATURE Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 3840 Lindell Blvd	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

