

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED AUG 2 - 1955

State File No. **24169**
Registrar's No. **5337**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois b. COUNTY Marion	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) Centralia	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) 1615 Morrison Road	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. John's Hospital			

3. NAME OF DECEASED (Type or Print)	a. (First) DRUSILLA	b. (Middle) C.	c. (Last) NOE	4. DATE OF DEATH (Month) (Day) (Year) June 19, 1955
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5. SEX Female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH July 27, 1892	9. AGE (In years last birthday) 62	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 1 HRS. Hours	IF UNDER 15 MIN. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (State or foreign country) Minneapolis, Minn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		

13a. FATHER'S NAME James Z. Cochran	13b. MOTHER'S MAIDEN NAME Almira Denny	14. NAME OF HUSBAND OR WIFE Dr. Phillip R. Noe
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. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Dr. Phillip R. Noe, Centralia, Ill.

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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Tumor of Stomach		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Carcinoma of Stomach (?) DUE TO (c) Metastatic Lesion to Brain		
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 None here. Had gastric resection at Mayo	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) Centralia (COUNTY) Marion (STATE) Ill.
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? 151X

22. I hereby certify that I attended the deceased from **6-4**, 19**55**, to **6-19**, 19**55**, that I last saw the deceased alive on **6-19**, 19**55**, and that death occurred at **8:30 am.**, from the causes and on the date stated above.

23a. SIGNATURE D. S. Allen M.D.	(Degree or title)	23b. ADDRESS 18 So Kings Highway, S.	23c. DATE SIGNED 6-20-55
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 6/20/55	24c. NAME OF CEMETERY OR CREMATORY -----	24d. LOCATION (City, town, or county) (State) Centralia, Illinois

DATE REC'D BY LOCAL REG. JUN 20 1955	REGISTRAR'S SIGNATURE J. Carl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE John J. Kassy	ADDRESS East St. Louis, Ill.
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(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

John J. Kossly

Licensed Embalmer No. 6855 *llc*

P. O. Address East St. Louis, Ill.

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.