

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-010333

STATE FILE NUMBER

FILED APR 15 1958

Registration District No. 150

Primary Registration District No. 5572

Registrar's No. 75

300
-57
008

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Rural - Prairie Twp.		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN Dodson
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Jackson Co Hosp.		Length of stay in lb 2 yrs	d. STREET ADDRESS (If outside, give location) Town
3. NAME OF DECEASED (Type or print) First Middle Last William Arthur Cochran			4. DATE OF DEATH Month Day Year April 3, 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 14, 1876
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (City and state & county) Illinois
13a. FATHER'S NAME John Cochran		13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Nora Bell 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. None	17. INFORMANT Address Mill, Mo. JacksCochran, 10424 Bristol, Hickman
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arterio Sclerotic Heart Disease DUE TO (b) Generalized Arterio Sclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH 4200
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from Feb 10, 1958 to April 3, 1958 and last saw her/him alive on April 3, 1958 Death occurred 2 P on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Philip A. Cooper M.D.		22b. ADDRESS Lee's Summit, Mo	
22c. DATE SIGNED 4-3-58			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
Burial	April 15, 1958	Palestine Cemetery	Hickman Mills, Mo.
24. FUNERAL DIRECTOR Langsford Funeral Home		25. DATE RECD. BY LOCAL REG. April 4-1958	26. REGISTRAR'S SIGNATURE D. B. Langsford

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only ink or ribbon type on this form. All diseases in Part I must be causally related.

APR 9 1958

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 Signature of Student Embalmer

Signed *[Signature]* Licensed Embalmer No. 4962 P.O. Address *[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 embalmed by a STUDENT, he also shall sign in his OWN handwriting. If this body is not embalmed, fact should be so stated above.