

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-1817972  
STATE FILE NUMBER

FILED MAY 19 1958 Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 23

1. PLACE OF DEATH a. COUNTY <b>Howell</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Arkansas</b> b. COUNTY <b>Sharp</b> admission <b>2030</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>West Plains</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Hardy</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>1218 W. Main St.</b>		Length of stay in 1b <b>24 days</b>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>ALICE</b> Middle <b>WRIGHT</b> Last <b>COCHRAN</b>			4. DATE OF DEATH Month <b>May</b> Day <b>10</b> Year <b>1958</b>
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5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 27, 1864</b>	9. AGE (In years last birthday) <b>94</b>	10. FUNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>homemaker</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>near Salem, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Adam S. Wright</b>	13b. MOTHER'S MAIDEN NAME <b>Rhoda Jane Durham</b>	14. NAME OF HUSBAND OR WIFE <b>Wm. David Cochran</b>
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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) <b>no</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT Address <b>Rus. Cochran, West Plains, Mo.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Cerebral arteriosclerosis</b>	<b>20 years</b>
	DUE TO (c) <b>Senility</b>	<b>332 X</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

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.)
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20c. TIME OF INJURY .Hour Month, Day, Year a.m. p.m.
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20d. INJURY OCCURRED WHILE AT <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
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21. I attended the deceased from **1953** to **5/10/58** and last saw her alive on **5/4/58**  
Death occurred at **5:30 a.** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>M. L. Fowler MD</b> (Degree or title)	22b. ADDRESS <b>West Plains Mo</b>	22c. DATE SIGNED <b>5/13/58</b>
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23a. MORTUARY REMOVAL (Specify)	23b. DATE <b>May 11, '58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Evening Shade Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>Evening Shade, Arkansas</b>
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24. FUNERAL DIRECTOR <b>Hal Thomburg</b> ADDRESS <b>THORN BURG FUNERAL HOME WEST PLAINS, MO.</b>	25. DATE RECD. BY LOCAL REG. <b>5-16-58</b>	26. REGISTRAR'S SIGNATURE <b>Beatrice Cook</b>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, or other person certifying cause of death must be causally related.

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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 Hal Tombergh

Licensed Embalmer No. 3408  
P. O. Address W. Plau

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.