

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-021533

STATE FILE NUMBER

FILED JUN 16 1958

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 568 A

300
1-57

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

1. PLACE OF DEATH a. COUNTY <u>Greene</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Polk</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Pleasant Hope Mo.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Johns.</u>		Length of stay in lb <u>10 DAYS</u>	d. STREET ADDRESS (If outside, give location) <u>NO STREET No.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>ROY</u> Middle <u>JAMES</u> Last <u>COCHRAN</u>			4. DATE OF DEATH Month <u>MAY</u> Day <u>30</u> Year <u>1958</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 16, 1884</u>	9. AGE (In years last birthday) <u>74</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Dentist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dentist</u>	11. BIRTHPLACE (City and state or country) <u>Pleasant Hope, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>M.H. Cochran</u>		13b. MOTHER'S MAIDEN NAME <u>MARY Abel</u>		14. NAME OF HUSBAND OR WIFE <u>Stella Cochran</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>495-38-2655</u>		17. INFORMANT Address <u>Pleasant Stella Cochran, Hope, Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a); (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA LIVER</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>CARCINOMA Biliary Ducts (Primary)</u> DUE TO (c) <u>1551</u> 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 <u>6 WEEKS</u>
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 Month, Day, Year a.m. p.m.					
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
21. I attended the deceased from <u>April 23-58</u> to <u>May 30-58</u> and last saw him alive on <u>May 29-58</u> Death occurred at <u>345 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Georgiyko M.D.</u> (Degree or title)		22b. ADDRESS <u>609 Chearyst-Springfield</u>		22c. DATE SIGNED <u>6-5-58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>June 1, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Hope Cem</u>		23d. LOCATION (City, town, or county) (State) <u>Pleasant Hope, Mo.</u>
24. FUNERAL DIRECTOR <u>ERWIN FUNERAL Home,</u>		ADDRESS <u>Bolivar Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>6-10-58</u>	26. REGISTRAR'S SIGNATURE <u>Effie G. Melton</u>	

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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 *Marshall C. Black*

Licensed Embalmer No. *4713*

P. O. Address *Bolivar, N*

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.