

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-036044  
STATE FILE NUMBER

Thomas E Cochran, M.D.

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1036

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>California</u> b. COUNTY <u>Orange</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		Inside Limits Year <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Santa Ana</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>Spring. Bah. Hosp.</u>		Length of stay in 1b <u>2 wks.</u>	d. STREET ADDRESS (If outside, give location) <u>510 Cypress Ave.</u> Reside on Farm 'Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Merritt</u> Middle <u>William</u> Last <u>Fouts</u>			4. DATE OF DEATH Month <u>Oct.</u> Day <u>27</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>June 2, 1910</u>
9. AGE (In years last birthday) <u>48</u>	10. UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	11. UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	9. AGE (In years last birthday) <u>48</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mach.</u>	11. BIRTHPLACE (City and state or country) <u>Kansas</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13a. FATHER'S NAME <u>Joseph Henry Fouts</u>	13b. MOTHER'S MAIDEN NAME <u>Grace Smith</u>
14. NAME OF HUSBAND OR WIFE <u>Ruby J. Fouts</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>510-03-1071</u>
17. INFORMANT Address <u>Ruby J. Fouts--Santa Ana, California</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>Acute myocardial Infarction</u> DUE TO (b) <u>Arteriosclerotic Heart disease</u> DUE TO (c) <u>4200</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>3 weeks</u> <u>6 years</u>		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.)	
20c. TIME OF INJURY Hour <u>  </u> Month <u>  </u> Day <u>  </u> Year <u>  </u> a.m. <u>  </u> p.m. <u>  </u>		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>10/10/58</u> to <u>10/27/58</u> and last saw her alive on <u>10/27/58</u> Death occurred at <u>4:30 hr.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Thomas E. Cochran M.D. Springfield, Mo.</u>		22b. ADDRESS <u>Springfield, Mo.</u>	22c. DATE SIGNED <u>10/29/58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>10-30-1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hope Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Arkansas City, Kansas</u>
24. FUNERAL DIRECTOR Address <u>Rex Rainey--Springfield, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>10-31-58</u>	26. REGISTRAR'S SIGNATURE <u>Effie E. Melton</u>

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK; OR RIBBON TYPEWRITE IF POSSIBLE

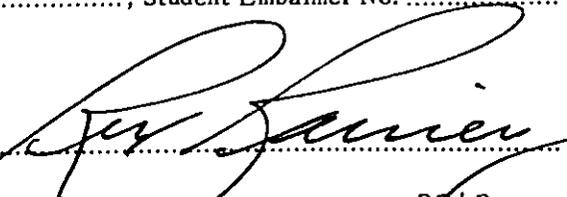
MEDICAL CERTIFICATION

NOV 5 1956

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 

Licensed Embalmer No. 3812  
P. O. Address Springfield, Mo

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.