

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-046948

STATE FILE NUMBER

FILED JAN 5 1958 Registration District No. 381 Primary Registration District No. 4515 Registrar's No. 140

1. PLACE OF DEATH a. COUNTY <u>SULLIVAN</u>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>SULLIVAN</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>MILAN 1050</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>SULL. CO MEML HOSP</u> Length of stay in 1b <u>8 DAYS</u>		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 <u>FRED</u> Middle <u></u> Last <u>COCHRAN</u>			4. DATE OF DEATH Month <u>DEC</u> Day <u>25</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>MAR. 27, 1883</u>	9. AGE (In years last birthday) <u>75</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>MILAN - SULLIVAN Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>

13. FATHER'S NAME <u>ROBERT COCHRAN</u>		14. MOTHER'S MAIDEN NAME <u>HARRIET CROCKER</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>487-14-6390</u>	
17. INFORMANT <u>MRS RUBY COCHRAN</u>		Address <u>MILAN 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>Lobar pneumonia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 da.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Fracture left hip.</u>		<u>10 da.</u>
	DUE TO (c) <u>Senile changes</u>		<u>9040</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>21</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.) <u>fell in home - with fire.</u>		
20c. TIME OF INJURY Hour <u>12:30</u> Month, Day, Year <u>12-14-58</u>			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. CITY, TOWN, OR LOCATION <u>Milam Sullivan MO</u>	

21. I attended the deceased from <u>12-14-58</u> to <u>12-25-58</u> and last saw her alive on <u>12-25-58</u> Death occurred at <u>4:10 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <u>E. W. Simpson D.O.</u>	22b. ADDRESS <u>Milam</u>
22c. DATE SIGNED <u>12-24-58</u>	

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>DEC 27, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>OAKWOOD CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>MILAN MO</u>
24. FUNERAL DIRECTOR <u>Wagon Funeral Home Milam</u>		25. DATE RECD. BY LOCAL REG. <u>12-29-58</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. M. W. Beckett</u>

(Licensed Embalmer's Statement on Reverse Side)

All symptoms will be listed. All necessary records maintained in Item 18. No symptoms will be listed. All necessary records maintained in Item 18. No symptoms will be listed. All necessary records maintained in Item 18. No symptoms will be listed. All necessary records maintained in Item 18.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Lucretia C. Rogers*.....

Licensed Embalmer No. *37*

P. O. Address *Melrose*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.