

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-010186  
STATE FILE NUMBER

FILED APR 10 1959

Registration District No. 216

Primary Registration District No. \_\_\_\_\_

Registrar's No. 23

1-57  
300

1. PLACE OF DEATH a. COUNTY <b>Mercer</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Mercer</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Princeton</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Mercer</b> <u>1650</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 <b>Lambert Hospital</b>		Length of stay in lb <b>3 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>Luvana</b> Middle <b>Elizabeth</b> Last <b>Cochell</b>			4. DATE OF DEATH Month <b>March</b> Day <b>25</b> Year <b>1959</b>		
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>June 4, 1876</b>		9. AGE (In years last birthday) <b>82</b> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (City and state or country) <b>Kentucky</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>

13a. FATHER'S NAME <b>Jeremiah Lemons</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Jane Loveless</b>		14. NAME OF HUSBAND OR WIFE <b>Sherman C. Cochell</b>	
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 <i>Grace Jenkins</i> Address <b>Ravanna Mo.</b>		

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>Hepatic failure</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Metastatic carcinoma</b>		<b>unkown</b>
	DUE TO (c) <b>Carcinoma of stomach</b>		<b>1 year</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.)		
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 <b>Princeton</b>	COUNTY <b>Mo.</b>	STATE <b>Mo.</b>
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21. I attended the deceased from **February 20, 1959** to **March 25, 1959** and last saw her alive on **March 25, 1959**  
Death occurred at **12:30** **p** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Frank A. Zolner</i> (Degree or title)	22b. ADDRESS <b>210 W. Main St. Princeton, Mo.</b>	22c. DATE SIGNED <b>3/13/59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Mar. 27, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Evergreen Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Lineville Iowa</b>
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24. FUNERAL DIRECTOR <i>Wm. Shurlee</i> ADDRESS <b>Lineville Iowa</b>	25. DATE RECD. BY LOCAL REG. <b>4-3-59</b>	26. REGISTRAR'S SIGNATURE <i>Harold Mass</i>
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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

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 *Amos L. Greaves*

Licensed Embalmer No. *3967*

P. O. Address *Summerville, S.C.*

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.