

I DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024759

Cochran FILED VS AUG 12 1959

Registration District No. 2000 Primary Registration District No. 2000 Registrar's No. 845

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY GREENE b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD Length of stay in 1b 5 DAYS. c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION SPRINGFIELD BAPTIST HOSPITAL Inside Limits <input checked="" type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE INDIANA b. COUNTY MARTON c. CITY OR TOWN INDIANAPOLIS Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) 1626 N. EUCLID AVE. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle B. Last GLASS			4. DATE OF DEATH Month AUG. Day 7 Year 1959				
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7/22/10	9. AGE (last birthday) 49	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done) ELECTRICAL ENGINEER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) INDIANA	12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME WILLIAM F. GLASS		13b. MOTHER'S MAIDEN NAME ELIZABETH BAKER		14. NAME OF HUSBAND OR WIFE ELEANOR E. GLASS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 303-07-8116	17. INFORMANT Address ELEANOR E. GLASS INDIANAPOLIS, IND.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____ PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					INTERVAL BETWEEN ONSET AND DEATH 6 hrs		
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 _____ a.m. _____ p.m. Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT WORK <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>August 7, 59</u> 9 A.M. to <u>Aug 7, 59</u> and last saw him alive on <u>Aug 7, 1959</u> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <i>Thomas E. Cochran M.D.</i> <i>by J. Callaway M.D.</i>			22b. ADDRESS Springfield, MO		22c. DATE SIGNED 8/8/59		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 8/10/59	23c. NAME OF CEMETERY OR CREMATORY WASHINGTON PARK, EAST		23d. LOCATION (City, town, or county) (State) INDIANAPOLIS, IND.			
24. FUNERAL DIRECTOR ADDRESS H.H. LOHMEYER SPRINGFIELD, MO.			25. DATE RECD. BY LOCAL REG. 8-10-59	26. REGISTRAR'S SIGNATURE <i>Effie S. Melton</i>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AUG 17 1961

FEB 16 1961

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Gene A. Hunt*

Licensed Embalmer No. 4739

P. O. Address *Spill, 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.