

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-002415

STATE FILE NUMBER

FILED VS FEB 8 1961

Registration District No. 264

Primary Registration District No.

Registrar's No. 8

1. PLACE OF DEATH a. COUNTY <b>Ozark</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Ozark</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Bridges Township</b>		c. CITY OR TOWN <b>Gainesville</b>	
Length of stay in 1b <b>life</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>None</b>		d. STREET ADDRESS (If outside, give location)	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Roy Alvin Cockrum</b>			4. DATE OF DEATH Month Day Year <b>1 27 61</b>
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>7-9-99</b>
9. AGE (last birthday) <b>61</b>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	11. BIRTHPLACE (City and state or country) <b>Caney, Mo.</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13. FATHER'S NAME <b>Richard Cockrum</b>	
13b. MOTHER'S MAIDEN NAME <b>Benonia Thompson</b>		14. NAME OF HUSBAND OR WIFE <b>Della Cockrum</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.	
17. INFORMANT <b>Mrs. Marvin Norton - Gainesville, Mo.</b>		Address	
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>Pulmonary edema</b>			INTERVAL BETWEEN ONSET AND DEATH <b>24 hr.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause (last). DUE TO (b) <b>Bronchial obstruction</b>			<b>1 mo.</b>
DUE TO (c) <b>Bronchiogenic carcinoma</b>			<b>6 mo.</b>
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
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 <b>1-27-61</b> to <b>1-27-61</b> and last saw <sup>her</sup> <sub>him</sub> <b>him</b> give on <b>1-27-61</b> Death occurred at <b>10:27</b> <b>P</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Arthur L. Beard, M.D.</b>		22b. ADDRESS <b>Gainesville, Mo.</b>	22c. DATE SIGNED <b>1-28-61</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>1-29-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Patrick cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Ozark County, Mo.</b>
24. FUNERAL DIRECTOR <b>Clinkingbeard.</b>	ADDRESS <b>Gainesville, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>2-1-61</b>	26. REGISTRAR'S SIGNATURE <b>Thana Mahan</b>

(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 DATE AMENDED  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 SHOULD READ  
 BY AFFIDAVIT OF

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 John P. Ware

Licensed Embalmer No. 4885

P. O. Address Guinnville, 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.