

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

22984

1. PLACE OF DEATH

County Jackson
Township KAW
City Kansas City

Registration District No. 399
Primary Registration District No. 1002
(No. General Hospital)

File No. _____
Registered No. 2976
St. _____ Ward _____

2. FULL NAME John Lewis Cochran

(a) Residence. No. 808 E. 27th St. St. 11 Ward. _____
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male	4. COLOR OR RACE White	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Hazel		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Not known		
7. AGE	YEARS	MONTHS
	27	<i>unk.</i>
8. OCCUPATION OF DECEASED		IF LESS than 1 day, _____ hrs. or _____ min.
(a) Trade, profession, or particular kind of work. Painter		<i>1865 194A</i>
(b) General nature of industry, business, or establishment in which employed (or employer)		<i>36</i>
(c) Name of employer		
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri		
PARENTS	10. NAME OF FATHER John W. Cochran	
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Not known	
	12. MAIDEN NAME OF MOTHER Not known	
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Not known	
14. INFORMANT Hazel Cochran (Address) 808 E. 27th St.		
15. FILED <u>7/20/30</u> <i>M.M. Cowie</i> <i>Post</i> REGISTRAR		

MEDICAL CERTIFICATE OF DEATH

3

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 19 1930

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at 5:50 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Accidental fracture of leg - 2nd fracture

CONTRIBUTORY (SECONDARY) *fell from scaffold* (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? *yes*

WHAT TEST CONFIRMED DIAGNOSIS? *autopsy*

(Signed) *[Signature]* M.D.
7.20.1930 (Address) *[Address]*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **Marshall, Missouri** DATE OF BURIAL **7-20-30**
19

20. UNDERTAKER **J.P. Louis Funeral Home** ADDRESS **City**

WRITE PLAINLY WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

