

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

Do not use this space.

21043

1. PLACE OF DEATH

County Lincoln

Registration District No. 491

File No. _____

Township _____

Primary Registration District No. 4298

Registered No. 29

City Tracy (No. _____) St. _____ Ward _____

2. FULL NAME

(a) Residence, No. _____ St. _____ 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 <u>Male</u>	4. COLOR OR RACE <u>Black</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)		
7. AGE	YEARS	MONTHS
	<u>82</u>	<u>11</u>
		DAYS
		<u>7</u>
		If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Farmer</u>
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)	11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St Charles Co

FATHER 13. NAME Arthur Cochrell

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St Charles

MOTHER 15. MAIDEN NAME Does not know

MOTHER 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS) Josephine Cochrell

18. BURIAL, CREMATION, OR REMOVAL PLACE Tracy County DATE June 14, 1934

19. UNDERTAKER (ADDRESS) Hempden Ave

20. FILED 7-1 1934 W.P. Smith Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 12 1934

22. I HEREBY CERTIFY That I attended deceased from 11-25, 1933, to June 12, 1934

I last saw him alive on June 4, 1934. Death is said to have occurred on the date stated above, at 2:00 P. m.

The principal cause of death and related causes of importance were as follows:

Apoplexy Date of onset 11-1-1933

Other contributory causes of importance:

Name of operation _____ Date of _____

What test confirmed diagnosis _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?

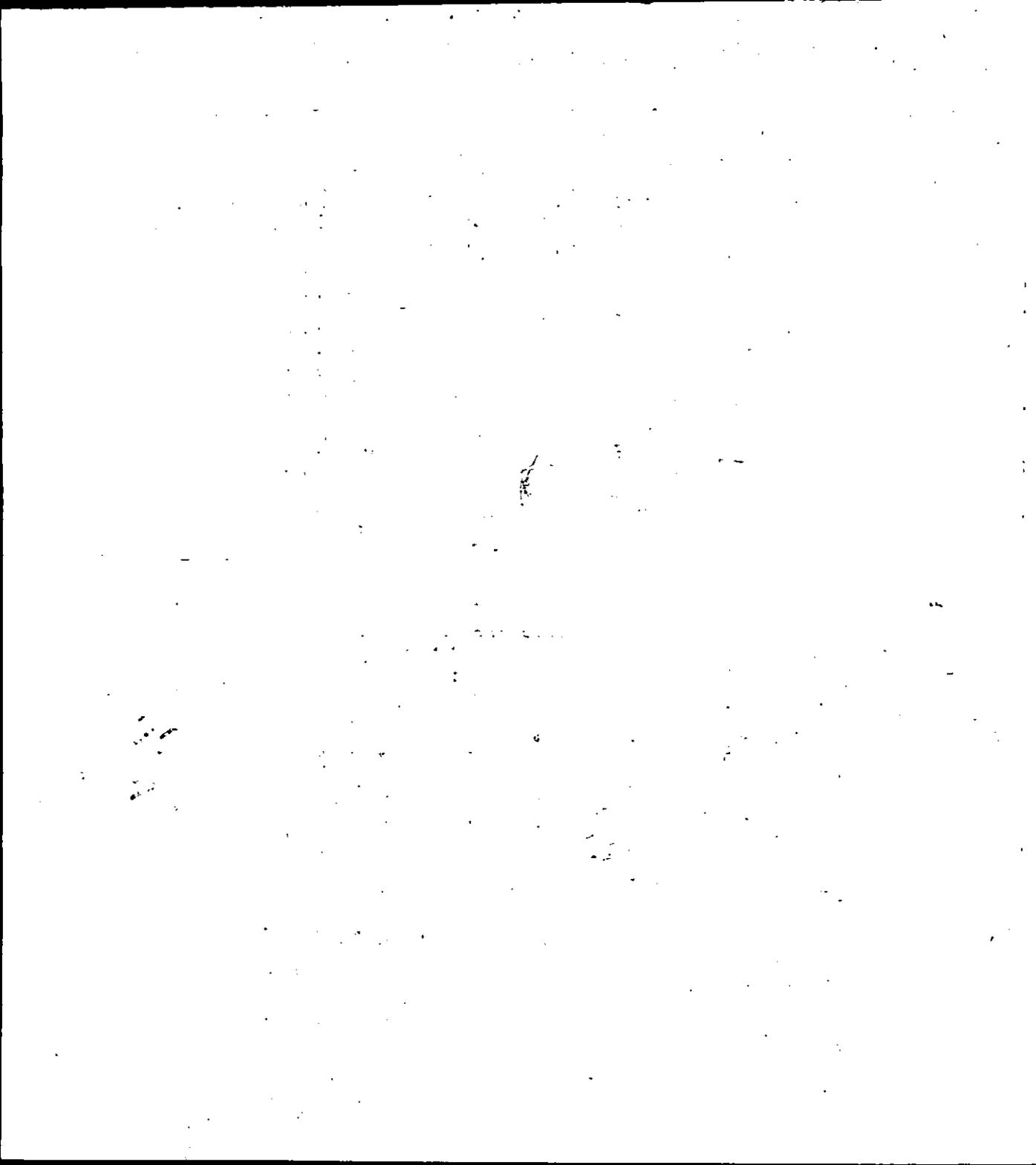
If so, specify _____

(Signed) J.C. Schroeder, D.C.

(Address) Tracy, Mo.

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.



Lincoln

DEPARTMENT OF COMMERCE
BUPEAU OF THE CENSUS
WASHINGTON

E. T. McLaugh, M. D.,
Special Agent,
Jefferson City, Mo.

22

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: *Guffin Cochrell*
Who died at _____ on *June 12 1934*
Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____

Sex *M* Color or race *Black* Single, married, widowed or divorced: _____

Date of birth *July 4-1851* Age: Years _____ Months _____ Days _____

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. (b) Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Date deceased last worked at this occupation: Month _____ Year _____

Birthplace (State or country) _____

Birthplace of father (State or country) _____

Birthplace of mother (State or country) _____

Principal cause of death: _____

Other contributory causes of importance _____

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19 _____

Where did injury occur? _____
(Specify city or town, county and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

Name of physician _____

Address of physician _____

Signature of Registrar *W. P. Smith*

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Reg. Dist. No. 491

Primary Reg. Dist. No. 4298

Very truly yours,

E. T. McLaugh M.D.

Special Agent.

g.c.

