

REC'D MAR 9 1939

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

5689  
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399  
 (b) Township 1st Primary Registration District No. 1002 Registered No. 888  
 (c) City N.E. MO (d) Street No. 110 San Hospit St.  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

(a) Residence, No. 2728 Holmes St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-27-39

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Edward Smith

22. I HEREBY CERTIFY, That I attended deceased from 2-25-39, 19... to 2-27-39, 19...  
 I last saw him alive on 2-27-39, 19... Death is said

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec - 26 1883

to have occurred on the date stated above, at 6:15 p.m.  
 The principal cause of death and related causes of importance were as follows:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
55 2 1

Pneumonia Date of onset

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

108

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

Other contributory causes of importance:

13. NAME Will Cochran

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

15. MAIDEN NAME Nancy Eckman

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

17. INFORMANT (ADDRESS) Record Clerk  
110 San Hospit

18. BURIAL, CREMATION, OR REMOVAL buried 27-39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Peter P. Hopkins  
336 Campbell

20. FILED 7-27 39 Dr. Brown Local Registrar.

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy? Yes

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) P. P. De Marco, M. D.

(Address) San Hospit

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.

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**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 .....

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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 this body is not embalmed, above space should be left blank.**