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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 2 1940

Registration District No. 85

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1001

State File No. 10264

Registrar's No. 345

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town Saint Joseph, (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Dr. E. D. Holme Nursing Home, (If not in hospital or institution, write street number or location) 3

(d) Length of stay: In hospital or institution 9 days, (Specify whether In this community 40 years, years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri, (b) County Buchanan

(c) City or town Saint Joseph, (If outside city or town limits write "RURAL")

(d) Street No. 3228 Seneca Street, (If rural, give location) 0

(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME Augusta A. Cochran, 265

3. (b) If veteran, name war None,

3. (c) Social Security No. None,

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife John P. Cochran,

6. (c) Age of husband or wife if alive ____ years

7. Birth date of deceased April 16, 1868 (Month) (Day) (Year)

8. AGE: Years 71 | Months 11 | Days 10 | If less than one day ____ hr. ____ min.

9. Birthplace Lucas County, (City, town, or county) Iowa, (State or foreign country) 1

10. Usual occupation At Home,

11. Industry or business

FATHER
12. Name James E. Holbrook,
13. Birthplace Unknown, (City, town, or county) Vermont, (State or foreign country) 1

MOTHER
14. Maiden name Louisa Cooper,
15. Birthplace Unknown, (City, town, or county) Iowa, (State or foreign country) 1

16. (a) Informant Miss Louise Cochran

(b) Address 3228 Seneca Street,

17. (a) Burial, (Burial, cremation, or removal) (b) Date thereof 3/29/40 (Month) (Day) (Year)

(c) Place: burial or cremation St. Jo. Mem. Park Cemetery

18. (a) Signature of funeral director Heston-Bergole Bowman Funeral

(b) Address 319 So. 10th. Str. Home

19. (a) 3/28/40 (Date received local registrar) (b) W. J. Mattlebush (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 26th. year 1940 hour 9:00 minute a M.

21. I hereby certify that I attended the deceased from March 17, 1940 to March 26, 1940; that I last saw her alive on March 26, 1940; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral Hemorrhage	
Due to Cerebral Hemorrhage	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations ✓
Of autopsy ✓

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

85 While at work? (e) Means of injury

23. Signature M. E. Holme (M. D. or other) 2

Address 236 Logan Bldg Date signed 3/26

(Licensed Embalmer's Statement on Reverse Side)

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 Wm E Summerfield

Licensed Embalmer No. 3007

P.O. Address 3198010 St Joseph

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.