

S. No. 2  
-11-10-33  
5-1-1933

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

27260

SEP 25 1940

State File No.

7156

Registration District No. 791

Primary Registration District No. 1003

Registrar's No.

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St Louis Mo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution St. Louis Children's Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 26 days  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Thomas Stephen Cochran

8. (b) If veteran, name war child 3. (c) Social Security No. child

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

8. AGE: Years \_\_\_\_\_ Months 7 Days 10 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Fort Benning Georgia (City, town, or county) (State or foreign country)

10. Usual occupation child

11. Industry or business \_\_\_\_\_

12. Name Loris R. Cochran

13. Birthplace Galena Kansas (City, town, or county) (State or foreign country)

14. Maiden name Adaline Martin

15. Birthplace Pierce City Mo. (City, town, or county) (State or foreign country)

16. (a) Informant Phosphat

(b) Address 500 S. Kinghighway

17. (a) removal (b) Date thereof 8-19-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Joplin Mo.

18. (a) Signature of funeral director J. B. Smith

(b) Address Maplewood Mo

19. (a) 24 (b) J. B. Smith  
(Date) (Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County \_\_\_\_\_

(c) City or town Joplin (If outside city or town limits, write "RURAL") NR

(d) Street No. 427 N. Maffett (If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8<sup>th</sup> day 17<sup>th</sup> year 1940 hour 9<sup>th</sup> minute 40/A.M.

21. I hereby certify that I attended the deceased from 7-22, 1940, to 8-17, 1940 that I last saw him alive on 8-17, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic ulcerative colitis acute broncho pneumonia Duration 2 mo 1 wk

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy Chronic ulcerative colitis acute bronchopneumonia

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature Fran V. Cooke M.D. (M. D. or other)

Address St. Louis Children's Hospital Date signed 9/17/40

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

MOTHER FATHER

AUG 24 1940

71516

7156

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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

*H. E. Burgess*

Licensed Embalmer No.

*4029*

P. O. Address

*Maplewood*

**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.