

Registration District No. 565

Primary Registration District No. 5761a

Registrar's No. 48

1. PLACE OF DEATH: Miller

(a) County \_\_\_\_\_

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

(c) Name of hospital or institution: At home  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community Life \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Miller

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

(d) Street No. Iberia, Mo. R# 1  
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME: SHERLEY COCHRAN

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 9  
year 1941 hour \_\_\_\_\_ minute 3:15 P. M.

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced. 0

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

7. Birth date of deceased Jan 14 - 1940  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Dec 27  
\_\_\_\_\_, 1940, to Jan 9, 1941;  
that I last saw her alive on Jan 9, 1941,  
and that death occurred on the date and hour stated above.

8. AGE: Years \_\_\_\_\_ Months 11 Days 25 If less than one day \_\_\_\_\_  
hr. \_\_\_\_\_ min. \_\_\_\_\_

Immediate cause of death Pneumonia, bronchial double

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

9. Birthplace Iberia Mo  
(City, town, or county) (State or foreign country)

Due to 107

Other conditions None  
(Include pregnancy within 3 months of death)

10. Usual occupation \_\_\_\_\_

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

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

Of autopsy \_\_\_\_\_

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

MOTHER FATHER { 12. Name Willard Cochran

13. Birthplace Iberia Mo  
(City, town, or county) (State or foreign country)

14. Maiden name Ma Fern Maneymaker

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

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

(a) Accident, suicide, or homicide (specify) 0

(b) Date of occurrence \_\_\_\_\_

16. (a) Informant Frank Maneymaker

(b) Address Iberia, Mo

17. (a) Burial (b) Date thereof 1/10-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation W. Union-Bunkley Mo.

(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? Y

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

18. (a) Signature of funeral director Chasey

(b) Address Iberia, Mo.

19. (a) 1113141 (b) CR Hawkins  
(Date received local registrar) (Registrar's signature)

23. Signature C. M. Little (M. D. or other) D

Address Crocker, Mo. Date signed 1-11-41

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

12113141

RECEIVED  
Miller County Health Dept.  
County File Number 41-24  
Date Filed 2/2/41

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.

No Embalming

Signed *Ch. Casey*  
Licensed Embalmer No. *2694*  
P. O. Address *Spencer, Mo*

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, fact should be so stated above.