

FILED JUN 17 1943

Registration District No. 560

Primary Registration District No. 3076

Registrar's No. 46

1. PLACE OF DEATH:

(a) County: Vernon  
(b) City or town: Warda  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
215 South Main St.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution ✓  
In this community About 56 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Vernon  
(c) City or town: Warda  
(If outside city or town limits, write "RURAL")  
(d) Street No. 215 South Main  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country: 0

3. (a) PRINT FULL NAME: Rose Rosina Cochrane

3. (b) If veteran, name war: no 3. (c) Social Security No.: no

4. Sex: Female 5. Color or race: White  
6. (a) Single, widowed, married, divorced: Widowed  
6. (b) Name of husband or wife: Wm J Cochrane  
6. (c) Age of husband or wife if alive: Dead years  
7. Birth date of deceased: April 17 - 1858  
(Month) (Day) (Year)

8. AGE: Years: 85 Months: 0 Days: 14  
If less than one day hr. min.

9. Birthplace: Lorain Ohio  
(City, town, or county) (State or foreign country)

10. Usual occupation: Housewife

11. Industry or business:

MOTHER FATHER { 12. Name: James Porter  
13. Birthplace: Unknown Ireland  
(City, town, or county) (State or foreign country)  
14. Maiden name: Unknown  
15. Birthplace: Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant: Miss May Cochrane  
(b) Address: 215 S. Main St. Warda, Mo.

17. (a) Burial (b) Date thereof: 5-12-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Warda Cemetery

18. (a) Signature of funeral director: Hayes Funeral Home  
(b) Address: Warda, Mo.

19. (a) 5-12-43 (b) Hazel B. Bawek  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 11  
year 1943 hour 1:05 minute A.M.

21. I hereby certify that I attended the deceased from May 10, 1943 to May 11, 1943  
that I last saw him alive on May 11, 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral Hemorrhage  
Duration: May 10 1943

Due to: Hypertension Don't know

Due to: Two or three previous cerebral hemorrhages

Other conditions: None  
(Include pregnancy within 3 months of death)  
Major findings: None  
Of operations: None  
Of autopsy: None

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? None (Specify type of place) (c) Means of injury: None

23. Signature: W. Love (M. D. or other)  
Address: Warda, Mo. Date signed: 5/11/43

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

RECEIVED

District Health Officer No. 7,

District File Number 5-43-558

Date filed 6-15-43

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 Mack A. Braswell

Licensed Embalmer No. 2529

P. O. Address Nevada 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.