

FILED NOV 19 1944
Registration District No. 324

Primary Registration District No. 3072

Registrar's No. 179

1. PLACE OF DEATH:

(a) County Saline
(b) City or town Marshall, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
279 So. Redman
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community All her Life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Saline 99
(c) City or town Marshall
(If outside city or town limits, write "RURAL") 1
(d) Street No. 279 So. Redman
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

3. (a) PRINT
FULL NAME Sarah Martha Cochran

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Samuel D. Cochran 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: January 30 1868
(Month) (Day) (Year)

8. AGE: Years 76 Months 8 Days 20 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name John B. Davis

13. Birthplace Unknown Kentucky
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Elizabeth Smith

15. Birthplace Unknown Virginia
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Frances Steele Cochran

(b) Address Marshall, Mo.

17. (a) Buried (b) Date thereof 10/22/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ridge of Cemetery

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Oct 30 - 44 (b) Thos T. Deibel
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 20
year 1944 AM _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____
1944 to Dec 20 1944
that I last saw her alive on Dec 19 1944
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Chronic myocarditis
Due to _____

General anesthesia 14 days
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations 93d
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) _____
While at work? _____ (e) Means of injury _____

23. Signature _____ (M.D. or other) _____

Address _____ Date signed 10/20/44

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

MOTHER FATHER

1215

RECEIVED

District

District File

11-9-47

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: *J. Leslie Sweeney*
Licensed Embalmer No. *3235*

P. O. Address *Marshall, 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.