FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED DEC 1 1947

Registration District No. 5-7

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3028

State File No. 38589

Registrar's No. 243

1. PLACE OF DEATH:
(a) County: Jasper
(b) City or town: Carthage (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 220 East Chestnut St. (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community: 16 years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Jasper
(c) City or town: Webb City (If outside city or town limits, write "RURAL")
(d) Street No.: 737 South Hall (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME: Wiley W. Cochran
3. (b) If veteran, name war: no data
3. (c) Social Security No. .....
4. Sex: male
5. Color or race: W.
6. (a) Single, widowed, married, divorced: widow
6. (b) Name of husband or wife .....
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased: March (Month) 13 (Day) 1872 (Year)

8. AGE: Years 76 Months 7 Days 26 If less than one day ..... hr. ..... min.

9. Birthplace: Newton County (City, town, or county) Missouri (State or foreign country)
10. Usual occupation: school teacher
11. Industry or business .....

MOTHER FATHER
12. Name: Finis B. Cochran
13. Birthplace: no data (City, town, or county) (State or foreign country)
14. Maiden name: no data
15. Birthplace: no data (City, town, or county) (State or foreign country)

16. (a) Informant: Daughter Mrs. R. T. Keith
(b) Address: Sorcorro, New Mex.
17. (a) burial (Burial, cremation, or removal) (b) Date thereof: 11/13/47 (Month) (Day) (Year)
(c) Place: burial or cremation: Anderson, Mo.
18. (a) Signature of funeral director: Hedge-Lewis
(b) Address: Webb City, Mo.
19. (a) 11-13-1947 (Date received local registrar) (b) L. B. Clinton (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Nov. day: 9th year: 1947 hour: 11 minute: P. M.

21. I hereby certify that I attended the deceased from Oct 29, 1947 to Nov 9, 1947 that I last saw alive on Oct 29, 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Embolic, Cerebral	3 hrs
Due to: Myocarditis Chronic	
Due to: arteriosclerosis Senility	
Other conditions: none (Include pregnancy within 3 months of death)	

Major findings:
Of operations: none
Of autopsy: none

PHYSICIAN — Underline the cause of 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: George F. Wood (M. D.) (or other)
Address: Carthage Mo. Date signed: Nov 12 '47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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

47-11-885

DEC 11 1947

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 Leonard J. Lewis Jr., Registered Apprentice No. 46, working under my personal supervision.

Signed [illegible]

Licensed Embalmer No. 2859

P. O. Address [illegible]

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.