

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
**MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH**

FILED APR 12 1948
Registration District No. 749

State File No. 8635
Registrar's No. 1341

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 19 days
(Specify whether
In this community 25 year
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 603 W. 37
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME James Cochran

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex Male 5. Color W/ht 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife unknown 6. (c) Age of husband or wife if alive deceased years
7. Birth date of deceased Dec 20, 1864
(Month) (Day) (Year)

8. AGE: Years 83 Months 3 Days 6 If less than one day
br. min.

9. Birthplace Decatur, Illinois (City, town, or county) (State or foreign country)

10. Usual occupation Retired 25 years

11. Industry or business

12. Name James Cochran

13. Birthplace Decatur, Illinois (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 Loyal Russell (b) Address 2805 Madison

17. (a) Removal (b) Date thereof 3-27-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pathology

18. (a) Signature of funeral director Smith Funeral Home (b) Address Pathology

19. (a) 3-27-48 (b) Genevieve Homes
(Date received local registration) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 26
year 1948 hour 1 minute 10 A.M.

21. I hereby certify that I attended the deceased from March 6, 1948 to March 26, 1948.
that I last saw him alive on March 26, 1948.
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary embolism

Due to probably thrombophlebitis in femoral vein

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 150 lb

Of autopsy None

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

3. Signature W. J. Smith (M. D. or other)

Med. Dir. Gen'l Hosp 3-26-48

Address Date signed

Duration

PHYSICIAN

Underline the cause of which death should be charged statistically.

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

Dr. Jansen

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 *Cecil R. Matthes*

Licensed Embalmer No. *3807*

P. O. Address *Kansas City, 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.