

FILED JUL 23 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 24177

709

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

BIRTH NO. _____ REG. DIST. NO. 233 PRIMARY REG. DIST. NO. 5813 Registrar's No. 20

1. PLACE OF DEATH a. COUNTY <u>Montgomery Co.</u>		2. USUAL RESIDENCE (Where deceased lived. If institutions, residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Montgomery</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Rural</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Middletown</u>	
c. LENGTH OF STAY (in this place) <u>✓</u>		d. STREET ADDRESS (If rural, give location) <u>3 Mi. N.W. of Wellsville</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION			
3. NAME OF DECEASED (Type or Print) a. (First) <u>James William Cochran</u> b. (Middle) _____ c. (Last) _____		4. DATE OF DEATH (Month) (Day) (Year) <u>July 14-1949</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct-12-1899</u>
9. AGE (In years, last birthday) <u>49</u>		10. MONTHS <u>9</u>	11. DAYS <u>2</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Welder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>	
11. BIRTHPLACE (State or foreign country) <u>Montgomery Co Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Sam Cochran</u>		13b. MOTHER'S MAIDEN NAME <u>Maggie Smith</u>	
14. NAME OF HUSBAND OR WIFE <u> Helen Cochran</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>Mrs Jim Holloway, Wellsville Mo</u>		ADDRESS <u>Wellsville Mo</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Decapitation</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Train-auto Collision</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Accident</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Wellsville</u>	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Montgomery MO</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>July 14 1949 10:27</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? <u>Auto - Train Collision</u>		<u>70</u>	
22. I hereby certify that I attended the deceased from <u>15 JULY, 19 49, to</u> , 19 <u> </u> , that I last saw the deceased alive on <u> </u> , 19 <u> </u> , and that death occurred at <u>10:27 a. m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>Clarence Summers</u>		23b. ADDRESS <u>Montgomery City Mo</u>	
23c. DATE SIGNED <u>7/15/49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>July 15 49</u>	
24c. NAME OF CEMETERY OR CREMATOR <u>West Prairie Chapel</u>		24d. LOCATION (City, town, or county) (State) <u>Middletown Mo</u>	
DATE REC'D BY LOCAL REG. <u>7/16/49</u>		REGISTRAR'S SIGNATURE <u>W. S. Romans Jr.</u>	
425		FUNERAL DIRECTOR'S SIGNATURE <u>W B Wells Wellsville Mo.</u>	
ADDRESS			

District File Number _____
District Health Officer No. 9
RECEIVED JUL 21 1949

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *A. B. Kellie*

Licensed Embalmer No. 1589

P. O. Address Kelleville 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.