

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34924

State File No.

FILED NOV 8 1957

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BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE _____ b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (in this place) Life		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		2049	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Res 6237 Clayton Ave.</u>				d. STREET ADDRESS (If rural, give location) <u>6237 Clayton Ave.</u>			
3. NAME OF DECEASED (Type or Print)		a. (First) <u>Willie</u>		b. (Middle) <u>T Laura</u>		c. (Last) <u>Cochran</u>	
4. DATE OF DEATH		(Month) <u>Oct.</u>		(Day) <u>25</u>		(Year) <u>1951</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Sept. 2, 1867</u>		9. AGE (In years last birthday) <u>84</u> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>St. Louis</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>John St. Clair</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Wm T. 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>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Ruth Finlay 327 N. Boyle</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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Ch. Hypertension, Heart Disease</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>Ch. Myocarditis</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Chronic</u>	
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)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>H</u>			
22. I hereby certify that I attended the deceased from <u>about 10 years</u> to <u>Oct 25</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>May 10</u> , 19 <u>51</u> , and that death occurred <u>at 9</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Ernest Smith M.D.</u>				23b. ADDRESS <u>496 1/2 Delmar Blvd</u>		23c. DATE SIGNED <u>10/26/51</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Oct. 27, 1951</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Bellefontaine Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis Mo.</u>	
DATE REC'D BY LOCAL REG. <u>OCT 26 1951</u>		REGISTRAR'S SIGNATURE <u>Ernest Smith M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Gleason & Sons</u>		ADDRESS <u>6175 Delmar</u>	

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

Dr Eugene Wohler
4968 a Delmar
Fo 4334
11-2

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 _____

working under my personal supervision.

Student Embalmer No.

Signed.....
Student Embalmer

Signed *jos. E. McCulloch*

Licensed Embalmer No. *2960*

P. O. Address *6175 Delmar*

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.