.S. No. 300
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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 17855

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 4195

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

1. PLACE OF DEATH
a. COUNTY St. Louis
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Louis
c. LENGTH OF STAY (In this place) 24 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) City Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Missouri
b. COUNTY ~~U.S.A.~~
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Louis, Mo. 2229
d. STREET ADDRESS (If rural, give location) 23 15 South 16th St.

3. NAME OF DECEASED (Type or Print)
a. (First) William
b. (Middle) —
c. (Last) Cochran

4. DATE OF DEATH (Month) May (Day) 2 (Year) 1952

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single
8. DATE OF BIRTH Sept 20 - 1882
9. AGE (In years last birthday) 69 | IF UNDER 1 YEAR Months 7 Days 12 | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor
10b. KIND OF BUSINESS OR INDUSTRY Common Labor
11. BIRTHPLACE (City and State or Foreign Country) Makanda, Ill.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Jessie Cochran
13b. MOTHER'S MAIDEN NAME Eliza Jackson
14. NAME OF HUSBAND OR WIFE —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) no
16. SOCIAL SECURITY NO. none
17. INFORMANT'S SIGNATURE OR NAME John Cochran ADDRESS St. Louis, Mo.

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Carcinoma of stomach with Metastasis to liver
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 [X] NO [ ]

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) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR? 151 X

22. *I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at 1100A m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) Patrick E. Taylor Coroner
23b. ADDRESS 1300 Clark
23c. DATE SIGNED 5-3-52

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE May 4/52
24c. NAME OF CEMETERY OR CREMATORY Oakland
24d. LOCATION (City, town, or county) (State) Carbondale, Ill.

DATE REC'D BY LOCAL REG. MAY 5 1952
REGISTRAR'S SIGNATURE J. Carl Smith MD
25. FUNERAL DIRECTOR'S SIGNATURE Joe F. Van Natta ADDRESS Carbondale, Ill.

(Licensed Embalmer's Statement on Reverse Side)

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 me.

Joe F. Van Natta, Student Embalmer No. ,

working under my personal supervision.

Student .....
Student Embalmer

Signed Joe F. Van Natta.

Licensed Embalmer No. 5246.

P. O. Address Carbondale, Ill.

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.