

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 409

BIRTH NO. <u>1160 FEB 15 1954</u>		REG. DIST. NO. <u>47</u>		PRIMARY REG. DIST. NO. <u>3008</u>		Registrar's No. <u>40</u>	
1. PLACE OF DEATH a. COUNTY <u>Callaway</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Montgomery</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Fulton, Mo.</u>		c. LENGTH OF STAY (In this place) <u>5 yrs - 5 mos.</u>		c. CITY OR TOWN <u>Bellflower, Mo.</u>		d. Is Residence within limits of a city or incorporated town? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>STATE HOSPITAL #1</u>				e. STREET ADDRESS (If rural, give location) <u>none</u>			
3. NAME OF DECEASED a. (First) <u>JAMES</u>			b. (Middle) <u>S.</u>		c. (Last) <u>COCHRAN</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Feb 10, 1954</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>never married</u>	8. DATE OF BIRTH <u>Mar. 25, 1868</u>		9. AGE (In years last birthday) <u>85</u>	IF UNDER 1 YEAR Months	IF UNDER 4 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13a. FATHER'S NAME <u>D.K.</u>			13b. MOTHER'S MAIDEN NAME <u>D.K.</u>		14. NAME OF HUSBAND OR WIFE <u>none</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 <u>Records of State Hospital #1, Fulton, Mo.</u>		ADDRESS	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)				MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pneumonia (Bronchial)</u>				DUPLICATE OF (b)			<u>2 weeks</u>
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.				DUPLICATE OF (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 type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>none</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		<u>491X</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept 17, 1953</u> , to <u>Feb 10, 1954</u> , that I last saw the deceased alive on <u>Feb 10, 1954</u> , and that death occurred at <u>7:45 P. M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Frank J. Nichols, M.D.</u> (Degree or title)				23b. ADDRESS <u>State Hospital #1, Fulton, Mo.</u>		23c. DATE SIGNED <u>2-10-54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>Feb 11-1954</u>		24c. NAME OF CEMETERY OR CREMATORY <u>St. Montgomery</u>		24d. LOCATION (City, town, or county) (State) <u>City, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>Feb 11-1954</u>		REGISTRAR'S SIGNATURE <u>Martha Lawrence</u> 426		25. FUNERAL DIRECTOR'S SIGNATURE <u>Schlanke Funeral Home</u> ADDRESS <u>Montgomery City, Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

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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.....  
Signature of Student Embalmer

Signed *E. Boone Schlanke*.....

Licensed Embalmer No... *413*.....

P. O. Address *Montgomery*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.