

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **2668**
Registrar's No. **0846**

FILED FEB 4 1954
BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois b. COUNTY Franklin	
b. CITY OR TOWN ST. LOUIS, MISSOURI	c. LENGTH OF STAY (in this place)	c. CITY OR TOWN Ewing	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION: BARNES HOSPITAL		e. STREET ADDRESS (If rural, give location) none	81208

3. NAME OF DECEASED (Type or Print) a. (First) CLEMENT b. (Middle) VERGIL c. (Last) COCHRANE			4. DATE OF DEATH (Month) (Day) (Year) JANUARY 26, 1954		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH June 15, 1901	9. AGE (In years last birthday) 52 If UNDER 1 YEAR: Months _____ Days _____ If UNDER 1 HR. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipe Fitter		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Illinois	
12. CITIZEN OF WHAT COUNTRY? US					

13a. FATHER'S NAME Lawrence Cochran	13b. MOTHER'S MAIDEN NAME Lilly Marshall	14. NAME OF HUSBAND OR WIFE Unknown
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. 334-01-8475	17. INFORMANT'S SIGNATURE OR NAME Gene Cochran ADDRESS Ewing, Illinois
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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) BRONCHOPNEUMONIA		DUE TO (b) POST OPERATIVE ENCEPHALOMALACIA		3-4 DAYS
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (c) ANEURYSM RIGHT SIDE OF THE BASILAR ARTERY		2 WEEKS
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				

19a. DATE OF OPERATION 1-13-54	19b. MAJOR FINDINGS OF OPERATION AS ABOVE	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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) 452X
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	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 **1-6**, 19**54**, to **1-26**, 19**54**, that I last saw the deceased alive on **1-26**, 19**54**, and that death occurred at **8:05 pm.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) C. J. Vermillion M.D.	23b. ADDRESS BARNES HOSPITAL	23c. DATE SIGNED 1-27-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 1-27-54	24c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery	24d. LOCATION (City, town, or county) (State) Mount Vernon, Illinois
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DATE REC'D BY LOCAL REG. JAN 27 1954	REGISTRAR'S SIGNATURE Charles Smith M.D.	FUNERAL DIRECTOR'S SIGNATURE Charles G. ... ADDRESS ...
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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)

Not Embalmed

Signed
Charles Kuruvu

Licensed Embalmer No. *480*

P. O. Address *East Hill*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.