FILED JUL 26 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26014
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6326

Health, Welfare Public Service

300
1-56

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

1. PLACE OF DEATH
a. COUNTY St. Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 40 Mo. Pac. Hosp. — Length of stay in 1b 5 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE ILL. b. COUNTY E. St. Louis
c. CITY OR TOWN E. St. Louis 912 — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 32 607 No. 33rd St. — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First WILLIAM Middle TOLBERT Last COCHRAN
4. DATE OF DEATH Month 7 Day 8 Year 57

5. SEX M
6. COLOR OR RACE W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 7/28/1886
9. AGE (In years last birthday) 70 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer
10b. KIND OF BUSINESS OR INDUSTRY Rail Road
11. BIRTHPLACE (City and state or country) Ava, Ill
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME George Cochran
14. MOTHER'S MAIDEN NAME Margaret Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Irene Cochran Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchi pneumonia
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Senility
DUE TO (c) Arteriosclerotic heart disease
INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 420.0
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 7/3/57, to 7/8/57 and last saw ~~her~~ him alive on 7/8/57
Death occurred at 6:45 AM. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) [signature] M.D.
22b. ADDRESS Mo Pac Hosp
22c. DATE SIGNED 7-8

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE July 11, 1957
23c. NAME OF CEMETERY OR CREMATORY Mt. Carmel
23d. LOCATION (City, town, or county) (State) Belleville, Ill

24. FUNERAL DIRECTOR Chas Burke ADDRESS East St. Louis, Ill
25. DATE RECD. BY LOCAL REG. JUL 8 57
26. REGISTRAR'S SIGNATURE J. Earl Smith M.D. MPA

(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 em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Chas M. Bu

Licensed Embalmer No. 2427

P. O. Address East St. Lo

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.