

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-029483

FILED VS SEP 2 1959

Registration District No. 156 Primary Registration District No. 2001 Registrar's No. 415

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Jasper</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Joplin</u> Length of stay in 1b <u>1 day</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jasper</u> c. CITY OR TOWN <u>Webb City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>722 W. Broadway</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St Johns Hospital</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>722 W. Broadway</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

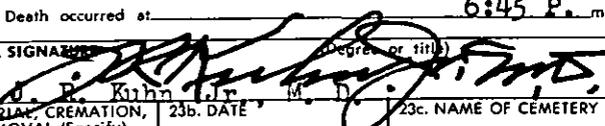
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>James</u> Last <u>Cochrane</u>			4. DATE OF DEATH Month <u>August</u> Day <u>20</u> Year <u>1959</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10-8-1887</u>	9. AGE (last birthday) <u>71</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Assayer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Nevada Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>William James Cochrane</u>			13b. MOTHER'S MAIDEN NAME <u>Rose Porter</u>		14. NAME OF HUSBAND OR WIFE <u>Lillian W. Cochrane</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.		17. INFORMANT Address <u>Mrs Lillian Cochrane - Webb City Mo.</u>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cirrhosis of the Liver</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Coronary Artery Disease</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>6-15-59</u> <u>7-27-54</u>
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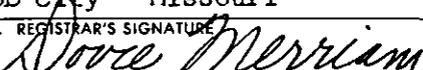
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)					
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			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 9-9-42 to 8-20-59 and last saw ^{her}him alive on 8-20-59
 Death occurred at 6:45 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title)  J. P. Kuhn, Jr. M.D.	22b. ADDRESS <u>321 Frisco Bldg., Joplin, Mo.</u>	22c. DATE SIGNED <u>8-22-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8-24-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mount Hope Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Webb City Missouri</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Hedge-Lewis Funeral Home-Webb City, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>8-27-1959</u>	26. REGISTRAR'S SIGNATURE 
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Richard Gray

Licensed Embalmer No. 440

P. O. Address Webb

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