

Fisher-Roller  
**MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-61-014477**  
 STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED **FILED APR 27 1961**  
 Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 153

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <b>Marion</b>	b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Hannibal</b>	a. STATE <b>Missouri</b>	b. COUNTY <b>Marion</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Levering</b>		c. CITY OR TOWN <b>Hannibal</b>	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
Length of stay in 1b		d. STREET ADDRESS <b>500a Bluff St.,</b>	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print)	4. DATE OF DEATH
First Middle Last <b>Robert Franklin Cockran</b>	Month Day Year <b>4/10/1961</b>

5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>3/8/1903</b>	9. AGE (last birthday) <b>58</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Centrallia, Ill.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Daniel Cockran</b>	13b. MOTHER'S MAIDEN NAME <b>Lucy Bell Beal</b>	14. NAME OF HUSBAND OR WIFE <b>- - -</b>
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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) <b>NO</b>	16. SOCIAL SECURITY NO.	17. INFORMANT <b>Mrs. Lucy Smallwood, 500a Bluff</b>	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Carcinoma nasopharynx with metastases</b>		<b>3 1/2 weeks</b>
Arteriosclerotic heart disease		
DUE TO (b) <b>Cardiac decompensation</b>		
DUE TO (c)		

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 checked="" type="checkbox"/> NO <input 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.)
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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
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21. I attended the deceased from <u>3/10/61</u> , to <u>4/10/61</u> and last saw her/him alive on <u>4/10/61</u> Death occurred at <u>12:15 P.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <b>M. J. Roller, M.D.</b> (Degree or title)	22b. ADDRESS <b>2910 St. Marys, Hannibal, Mo.</b>	22c. DATE SIGNED <b>4/15/61</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>4/12/1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Hannibal, Mo.</b>
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24. FUNERAL DIRECTOR <b>H.M.O'Donnell, Hannibal, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>4/25/61</b>	26. REGISTRAR'S SIGNATURE <b>Dr. E.M. Rucke by Lillian M. Sherman</b>
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DATE AMENDED  
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 SHOULD READ  
 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 me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed *J. M. O'Donnell*

Licensed Embalmer No. 3889

P. O. Address Hannibal, Mo.

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.