

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

5470-61-040986 STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. _____

UNRECORDED

FILED NOV 17 1961

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI COUNTY JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		c. CITY OR TOWN KANSAS CITY	
Length of stay in 1b 2 YEARS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3716 WALNUT STREET		d. STREET ADDRESS (If outside, give location) 3716 WALNUT STREET	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last VIRGINIA B. COCHRAN			4. DATE OF DEATH Month Day Year NOVEMBER 1 1961		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3/29/77	9. AGE (last birthday) 84	IF UNDER 1 YEAR Months Days 11 1

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME	10b. KIND OF BUSINESS OR INDUSTRY ---	11. BIRTHPLACE (City and state or country) HENDERSON COUNTY, MO.	12. CITIZEN OF WHAT COUNTRY U.S.A.
---	---	--	--

13a. FATHER'S NAME James Henry Baxter		13b. MOTHER'S MAIDEN NAME America Frances Carson		14. NAME OF HUSBAND OR WIFE CHARLES E. COCHRAN	
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. NONE		17. INFORMANT MRS. WILMA HICKOK	

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 1 year
IMMEDIATE CAUSE (a) Chronic myocarditis			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Hypertension			
DUE TO (c) Senility arteriosclerosis			10 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) NO			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

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. NO	Month, Day, Year
--	------------------

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NO	20f. CITY, TOWN, OR LOCATION NO	COUNTY NO	STATE NO
---	---	---	---------------------	--------------------

21. I attended the deceased from June 1959 to 11-1-61 and last saw her live on 11-1-61.
Death occurred at 2:00 A. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE M. B. Casebolt	(Degree or title) MD	22b. ADDRESS 4000 W. Altamere	22c. DATE SIGNED 11-1-61
---	--------------------------------	---	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE Nov. 4, 1961	23c. NAME OF CEMETERY OR CREMATOR FOREST HILL CEMETERY	23d. LOCATION (City, town, or county) KANSAS CITY	(State) MISSOURI
--	----------------------------------	--	---	----------------------------

24. FUNERAL DIRECTOR D.W. NEWCOMER'S SONS	ADDRESS 1331 BRUSH CR. KANSAS CITY, MO.	25. DATE RECD. BY LOCAL REG. 11-2-61	26. REGISTRARS SIGNATURE Ruth Long
---	---	--	--

DOCUMENT

BY AFFIDAVIT OF M. B. Casebolt MEDICAL CERTIFICATION

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 Louis Quest

Licensed Embalmer No. 4096

P. O. Address K.C. 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.