

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-004838

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 241

AMENDED

**FILED JAN 29 1962**

1. PLACE OF DEATH a. COUNTY <b>St Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO</b> b. COUNTY <b>ST LOUIS</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Richmond Heights.</b>		Length of stay in 1b <b>Life</b>	c. CITY OR TOWN <b>ST LOUIS</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Marys Hosp.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>433 8 CRANFORD DR</b>
3. NAME OF DECEASED (Type or print) First <b>Baby</b> Middle <b>Cochran</b> Last <b>Cochran</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>15</b> Year <b>1962</b>	

5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>1/15/1962</b>	9. AGE (last birthday) IF UNDER 1 YEAR: Months <b>1</b> Days <b>3</b> IF UNDER 24 HR: Hours <b>1</b> Min. <b>3</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (City and state or country) <b>Richmond Heights Mo</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>

13a. FATHER'S NAME <b>Richard Cochran</b>	13b. MOTHER'S MAIDEN NAME <b>Mary McDermott</b>	14. NAME OF HUSBAND OR WIFE <b>None</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   (If yes, give war or dates of service) <b>No None</b>	16. SOCIAL SECURITY NO. <b>Nonen</b>	17. INFORMANT Address <b>Mr. Richard Cochran 4338 Cranford dr.</b>

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intera Uterine Rupture by xiation</b>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Abruptus Placenta - Maternal</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

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 <b>St. Louis</b>	COUNTY <b>St. Louis</b>	STATE <b>Mo</b>
21. I attended the deceased from _____, to _____ and last saw her/him alive on _____ Death occurred at <b>7:55</b> <b>A.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE <b>John B. O'Hair M.D.</b>	(Degree or title)	22b. ADDRESS <b>634 North Grand Ave</b>	22c. DATE SIGNED <b>1/16/62</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>1/18/62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery</b>	23d. LOCATION (City, town, or county) <b>St. Louis County Mo</b>
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24. FUNERAL DIRECTOR <b>Calvin F. Feutz 4828 Natural Bridge Blvd.</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>1-18-62</b>	26. REGISTRAR'S SIGNATURE <b>John B. Murphy M.D.</b>
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Ms Heather Boley

Baby was not embalmed packed in fluid

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 \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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.