

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**63-005009**

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 1 Primary Registration District No. --- Registrar's No. 78

**FILED MAR 12 1963**

VS 300  
Rev. 4/59

0010  
20010-

3  
4 0  
5 1  
6  
7 0  
8 1  
9451X

10  
11  
12 90-2  
13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>Adair</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Adair</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Sperry</b>		Length of stay in 1b	c. CITY OR TOWN <b>Greentop</b>	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>AT HOME</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>RFD # 1</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Saul Cassius Cochran</b>			4. DATE OF DEATH Month <b>February</b> Day <b>28</b> Year <b>1963</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>7/20/94</b>	9. AGE (last birthday) <b>68</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Agriculture</b>	11. BIRTHPLACE (City and state or country) <b>Harris, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Robert H. Cochran</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Lydia Reger</b>		14. NAME OF HUSBAND OR WIFE <b>Myrtle Cochran</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of)		16. SOCIAL SECURITY NO. <b>833</b>	17. INFORMANT Address <b>RFD # 1</b> <b>Mrs. Saul C. Cochran - Greentop, Mo.</b>		
18. CAUSE OF DEATH (Enter only one cause permitted for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Peripheral Circulatory Failure</b> DUE TO (b) <b>Hemorrhage</b> DUE TO (c) <b>Rupture of Dissecting Aortic Aneurysm</b>				INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>  <b>Immediate</b>  <b>Immediate</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Nephrosclerosis, Prostatic Hypertrophy, Hypertension</b>				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 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.)			
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>Kirkville</b>		COUNTY <b>Harris</b>	STATE <b>Mo.</b>
21. I attended the deceased from <b>1-7-63</b> to <b>2-28-63</b> and last saw her/him alive on <b>2-27-63</b> Death occurred at <b>5:50 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>E. Besterman D.O.</b>			22b. ADDRESS <b>Kirkville, Mo.</b>		22c. DATE SIGNED <b>3/2/63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>3/3/63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Asbury Cemetery</b>		23d. LOCATION (City, town, or county) <b>Harris, Mo.</b>	
24. FUNERAL DIRECTOR <b>Davis &amp; Davis</b>			ADDRESS <b>Kirkville</b>	25. DATE RECD. BY LOCAL REG. <b>3-3-1963</b>	26. REGISTRAR'S SIGNATURE <b>Doris W. Redliff</b>

USE BLACK INK OR TYPEWRITER RIBBON

MAR 13 1963

RECEIVED

ED BESTMAN, D.D.

Paraffinized March 3, 1963

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 Robert B. Harris

Licensed Embalmer No. 4219

P. O. Address Kirksville, 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.