

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-006444

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **149** Registration District No. **1002** Registrar's No. **1288**

FILED MAR 15 1963

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

OWNERS

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY SULLIVAN	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY, MISSOURI		Length of stay in 1b 7 Hrs	c. CITY OR TOWN MILAN
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VA HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last BRUCE ROBERT COCHRAN			4. DATE OF DEATH Month Day Year February 26 1963
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4-12-12
9. AGE (last birthday) 50 yrs		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)		10b. KIND OF BUSINESS OR INDUSTRY MILAN, MISSOURI	12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME SAMUEL COCHRAN		13b. MOTHER'S MAIDEN NAME ERMA PRICE	
14. NAME OF HUSBAND OR WIFE —		15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates) NO YES NO	
16. SOCIAL SECURITY NO.		17. INFORMANT VA HOSPITAL OFFICIAL RECORDS	
18. CAUSE OF DEATH (Enter only one cause permitting the use of (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (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) Military Heart & Coronary Branchitis			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 s.m. p.m. 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.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from February 25, 1963 8:00 PM to Feb 26, 1963 3:36 A m on the date stated above, and to the best of my knowledge, from the causes stated. Death occurred at 3:36 A m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Sheila Owens		22b. ADDRESS 152 Mission Station 3-246	
22c. DATE SIGNED 2-26-63		22d. LOCATION (City, town, or county) (State) Milan, Mo.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2-26-63	
23c. NAME OF CEMETERY OR CREMATORY Sheil Funeral Home - K.C. Mo.		23d. LOCATION (City, town, or county) (State) Milan, Mo.	
24. FUNERAL DIRECTOR Sheil Funeral Home - K.C. Mo.		25. DATE RECD. BY LOCAL REG. 2-26-63	
26. REGISTRAR'S SIGNATURE Ruth Long			

USE BLACK INK OR TYPEWRITER RIBBON

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 *Thomas A. Smith*

Licensed Embalmer No. 4954

P. O. Address J. P. M.

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.

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