

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-017492

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4622

FILED MAY 2 1963

VS 300 Rev. 4/59	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF
1	6-27-63	
281207	6-27-63	
3		
4	2	
5	1	
6		
7	0	
8	1	
9		
10		
11		
12	52-0	
13		
52		

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		c. CITY OR TOWN Edwardsville	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. STREET ADDRESS Edwardsville, Ill. 1024 Highland	
3. NAME OF DECEASED (Type or print) Dr. CLIFTON R. COCHRAN		4. DATE OF DEATH Month April Day 24 Year 1963	
5. SEX Male	6. COLOR OR RACE Negro	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9-22-1904
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Doctor		11. BIRTHPLACE (City and state or country) St. Louis, Mo.	
13a. FATHER'S NAME John Cochran		13b. MOTHER'S MAIDEN NAME Maude Alexander	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates)		17. INFORMANT Lena Mae Cochran-1024 Highland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SUB DIAPHRAGMATIC ABSCESS		INTERVAL BETWEEN ONSET AND DEATH Week & 1/2	
DUE TO (b) Cholecystectomy		1 mon.	
DUE TO (c) Cholecystitis		1 mon.	
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 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 Month, Day, Year s.m. p.m.	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
21. I attended the deceased from 4/24/63 to 4/24/63 and last saw him alive on 4/24/63 Death occurred at 5:25 p.m. m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE [Signature] (Degree or title) M.D.		22b. ADDRESS BARNES HOSPITAL	
22c. DATE SIGNED 4/25/63			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 4-29-63	23c. NAME OF CEMETERY OR CREMATORY St. Peters Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis, Missouri
24. FUNERAL DIRECTOR ADDRESS A. L. Beal Und. Co. 4303 Delmar		25. DATE RECD. BY LOCAL REG. APR 27 1963	26. REGISTRAR'S SIGNATURE [Signature]

DOCUMENT BY AFFIDAVIT OF *[Signature]* MEDICAL CERTIFICATION

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

Arthur L. Heiland

Licensed Embalmer No. 4921

P. O. Address 3100 Boston Ave

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.