

S. No. 2  
DM-5-43  
v. 5-17-39  
I X3667

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED SEP 22 1947

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

*Barnum*  
State File No. 33420  
Registrar's No. \_\_\_\_\_

Registration District No. 236

Primary Registration District No. 6131

1. PLACE OF DEATH:  
(a) County Shannon  
(b) City or town Mountain View, Mo Rural  
(c) Name of hospital or institution: NO  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution NO  
In this community 64 Years  
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Shannon (b) County Missouri  
(c) City or town Mountain View, Mo  
(d) Street No. Rural  
(e) Citizen of foreign country? NO  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Emma Ella Cochran  
3. (b) If veteran, name war No  
3. (c) Social Security No. No

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Aug, day 28th  
year 1947 hour 12 minute 45 P. M.  
21. I hereby certify that I attended the deceased from Aug 8, 1946, to Aug 29, 1947.  
that I last saw her alive on Aug 27, 1947,  
and that death occurred on the date and hour stated above.  
Immediate cause of death Cerebral Hemorrhage

4. Sex Female 5. Color or race W  
6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased July 16th  
(Month) (Day) (Year)

Duration  
Due to Hypertension  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

8. AGE: Years 78 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Hazel Kentucky  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name A. Smotherman

13. Birthplace Kentucky  
(City, town, or county) (State or foreign country)

14. Maiden name Mary Cooper

15. Birthplace Kentucky  
(City, town, or county) (State or foreign country)

16. (a) Informant Syble Orchard

(b) Address Mountain View, Mo

17. (a) Burial (b) Date thereof Aug 31 47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pleasant Grove Cem

18. (a) Signature of funeral director Lee R. Stroman

(b) Address Mountain View, Mo

19. (a) 9-20-47 (b) Walter P. Rice  
(Date received local registrar) (Registrar's signature)

PHYSICIAN  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature Storley Barnum (M. D. or other) D.O.  
Address Mill District Date signed 9-2-47

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

63 / 36  
6/21/89

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**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.....

....., Registered Apprentice No. ....

working under my personal supervision.

Signed.....

*Joe R. Duncan*

Licensed Embalmer No. ....

4325

P. O. Address.....

*M. K. King 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 this body is not embalmed, fact should be so stated above.**