N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County: St Francois

Township: Randolph
or
Village: Desloge
or
City: ____ (NO. ____ St.: ____ Ward)

Registration District No. 779 File No. 2 15685

Primary Registration District No. 6024a Registered No. ____

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Howard Raymond Couch

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

SINGLE, ~~MARRIED~~, ~~WIDOWED~~ OR DIVORCED (Write the word)

DATE OF BIRTH: 4-6 (Month) (Day), 1916 (Year)

AGE: 1 yrs. 3 mos. 6 ds.

If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): "

BIRTHPLACE (City or town, State or foreign country): Desloge Mo

PARENTS

NAME OF FATHER: Willis W Couch

BIRTHPLACE OF FATHER (City or town, State or foreign country): Ware Mo

MAIDEN NAME OF MOTHER: Willie M Macatee

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Rich Woods

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): Willis W Couch

(ADDRESS): Desloge Mo

Filed 4 7, 1916 G W Son REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: 4-6 (Month) (Day), 1916 (Year)

I HEREBY CERTIFY, that I attended deceased ~~from~~ 4-6, 1916, to ____, 1916, that I last saw h~~m~~ alive on 4-6, 1916, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

1 Pertussis
2 followed by Convulsions

(Duration) 1 yrs. 3 mos. 6 ds.

Contributory (SECONDARY): —

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) G W Son M. D.

4/6, 1916 (Address) Desloge

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death? ____

Former or usual residence ____

PLACE OF BURIAL OR REMOVAL: Ware Mo

DATE OF BURIAL: April 8, 1916

UNDERTAKER: Kenny Rinker

ADDRESS: Flat Rock Mo

Revised United States Standard Certificate of Death

MISSOURI STATE BOARD OF H
BUREAU OF VITAL STATISTIC
CERTIFICATE OF DEATH

PLACE OF DEATH

County _____

Township _____ Registration District No. _____ File No. _____

or

Village _____ Primary Registration District No. _____ Registered No. _____

or

City _____ (NO. _____, _____ St.; _____ Ward) [If death hospital give its of street a

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH _____ (Month) _____ (Day), 1 _____ (Year)

AGE _____ yrs. _____ mos. _____ ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country)

PARENTS
- NAME OF FATHER
- BIRTHPLACE OF FATHER (City or town, State or foreign country)
- MAIDEN NAME OF MOTHER
- BIRTHPLACE OF MOTHER (City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191__, _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____ (Da

I HEREBY CERTIFY, that I attended dec _____, 191__, to _____ that I last saw h _____ alive on _____ and that death occurred, on the date stated above, The CAUSE OF DEATH* was as follows:

_____

_____

_____ (Duration) _____ yrs. _____ m

Contributory (SECONDARY) _____

_____ (Duration) _____ yrs. _____ m

(Signed) _____

_____, 191__ (Address) _____

*State the Disease Causing Death, or, in deaths from Vi (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homic

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DATE O
UNDERTAKER	ADDRES