

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

Do not use this space.

21429

1. PLACE OF DEATH

County Jackson
Township Kaw
City Kansas City

Registration District No. 895
Primary Registration District No. 000
(No. Very High)

File No. _____
Registered No. 2551
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. RR # 5 St. _____ Ward _____
(Usual place of abode)

John Kansas City, Mo.
(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Infant

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 3 - 1931

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
— 1 6

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer) none
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Missouri

10. NAME OF FATHER Harry P. Couch

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Mo.

12. MAIDEN NAME OF MOTHER Alvie Boak

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Mo.

14. INFORMANT Harry P. Couch
(Address) RR # 5

15. FILED 6/10 31 M. M. Croome
REGISTRAR

4 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 9 1931

17. I HEREBY CERTIFY, That I attended deceased from June 3, 1931, to June 9, 1931 that I last saw h. ex. alive on June 9, 1931, and that death occurred, on the date stated above, at 11 pm m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Insect Bite Rt Cheek
(Type unknown)

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (SECONDARY) Erysipelas secondary to above
strep. septemicum, & peritonitis
(duration) yrs. mos. 7 ds.

18. WHERE WAS DISEASE CONTRACTED

NOT AT PLACE OF DEATH Home

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical appearance
(Signed) D. D. Muley, M. D.

6-9 1931 (Address) B. Murphy

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Koshkovong - Mo. June 10, 1931

20. UNDERTAKER ADDRESS Mrs. C. L. Frater K. P. #10

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.

WHILE PRINTING WITH UNFADING INK—THIS IS A PERMANENT RECORD

