

FILED OCT 18 1940

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

32659

Do not use this space.

1. PLACE OF DEATH **New Madrid** 20 Registration District No. **600**
 (a) County **Como** Primary Registration District No. **4559** Registered No. _____
 (b) Township _____
 or _____
 (c) City _____ (d) Street No. _____ St. _____
 (e) Length of residence in city or town where death occurred yrs. mos. da. **one hour** (f) How long in U. S., if of foreign birth? yrs. mos. da. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)

2. PRINT FULL NAME **Baby Couch**
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED **Single**
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **9-6-40**
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. _____
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **nil**
 9. Industry or business in which work was done, as saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **New Madrid Co. Mo.**
 FATHER 13. NAME **John Willis Couch**
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Illinois**
 MOTHER 15. MAIDEN NAME **Adel Bernice Stinson**
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **New Madrid Co., Mo.**
 17. INFORMANT **J. W. Couch**
 (ADDRESS) _____
 18. BURIAL, CREMATION, OR REMOVAL PLACE **Parma** DATE **Sept 6 1940**
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) **none 531**
 20. FILED **9/6/40** 19 **Dr. Goodrich** Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **9-6-40** 19**40**
 22. I HEREBY CERTIFY, That I attended deceased from **9-6-40**, 19____, to **9-6-40**, 19____
 I last saw him alive on **9-6-40**, 19____. Death is said to have occurred on the date stated above, at **9:00A. M.**
 The principal cause of death and related causes of importance were as follows:
Premature birth
 Date of onset _____
 Other contributory causes of importance: **159**
 Name of operation _____ Date of _____
 What test confirmed diagnosis **chest** Was there an autopsy? **yes**
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____
 Manner of injury _____
 Nature of injury _____
 24. Was disease or injury in any way related to occupation of deceased? **?**
 If so, specify _____
 (Signed) **W. J. Gilman, M.D.**
 (Address) **Parma Mo**

(Licensed Embalmer's Statement on Reverse Side)

K. 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.

RECEIVED

District Health Officer No. 2,

District File Number 1040-150

Date Filed 10/14/40

180 910

01-5-6

02-3-6

01-8-6

11

0:000 2

Picture Print

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.....

Licensed Embalmer No.....

P. O. Address.....

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, above space should be left blank.