

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 6 1945
STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **28938**
Registration District No. **318**
Primary Registration District No. **1003**
Registrar's No. **8566**

1. PLACE OF DEATH:

(a) County.....
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Childrens Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
(Specify whether
In this community
years, months or days)

3. (a) PRINT FULL NAME Sharon Ann Couch

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced Infant

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased 6 16 1945
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
3 15 hr. min.

9. Birthplace Jefferson City Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

12. Name Robert W. Couch

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

14. Maiden name Helen Shepard

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

16. (a) Informant Robert W. Couch

(b) Address 304 Hamlin Avenue, Jeff. City

17. (a) Removal (b) Date thereof 10 2 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Jefferson City, Mo.

18. (a) Signature of funeral director Alexander & Sons

(b) Address 6175 Delmar Boulevard

19. (a) OCT 2 1945 J. F. Bredeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 26
(c) City or town Jefferson City 5
(If outside city or town limits, write "RURAL")
(d) Street No. 304 Hamlin Avenue 4 NR
(If rural, give location)
(e) Citizen of foreign country? 1 (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 1
year 1945 hour 6 minute 00 P. M.

21. I hereby certify that I attended the deceased from 9 - 27 1945 to 10 - 1 1945;
that I last saw h. er alive on 10 - 1 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Influenza meningitis Duration
3 1/2

Due to.....

Due to.....

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....

Of autopsy.....

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 K. J. Beck (M. D. or other).....

Address on St. Kemp Date signed.....

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

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.....
Thomas R. Fenwick

Licensed Embalmer No. 3793

P. O. Address.....
St. Louis, 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.