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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 16 1948

Registration District No. _____

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

449

State File No. _____

Primary Registration District No. 3010

Registrar's No. 44

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

1. PLACE OF DEATH:

(a) County: Cape Girardeau

(b) City or town: Cape Girardeau (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St Francis Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 1 day (Specify whether years, months or days) In this community: 6 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo (b) County: Cape Gir

(c) City or town: Cape Girardeau (If outside city or town limits, write "RURAL")

(d) Street No.: 743 Bellbony (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country: _____

3. (a) PRINT FULL NAME: RACHEL CENIE IRVIN 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: Married

6. (b) Name of husband or wife: George

6. (c) Age of husband or wife if alive: 87 years

7. Birth date of deceased: May (Month) 1 (Day) 1867 (Year)

8. AGE: Years: 80 Months: 8 Days: 30 If less than one day: hr. min.

9. Birthplace: Lyneville (City, town, or county) Ind (State or foreign country)

10. Usual occupation: at home

11. Industry or business: _____

FATHER
12. Name: Marion Corn
13. Birthplace: Ind (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Susan
15. Birthplace: Ind (City, town, or county) (State or foreign country)

16. (a) Informant: Mrs Agnes Morrison
(b) Address: Cape Girardeau, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 2-3-48 (Month) (Day) (Year)
(c) Place: burial or cremation: Morley Mo

18. (a) Signature of funeral director: Welch Funeral Home
(b) Address: Sikeston Mo.

19. (a) 2-7-48 (Date received local registrar) (b) C. C. Summers (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Feb day: 1 year: 1948 hour: 5 minute: 29 P.M.

21. I hereby certify that I attended the deceased from Jan. 31, 1948 to Feb. 1, 1948; that I last saw him alive on Feb. 1, 1948 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral Hemorrhage	3 days
Due to:	
Due to:	
Other conditions: Hypertension (Include pregnancy within 3 months of death)	Yr.
Major findings: Of operations:	
Of autopsy:	

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? (Specify type of place)
While at work? (e) Means of injury: 0

23. Signature: D. J. Oehler (M.D. ~~or other~~)
Address: Cape Girardeau, Mo Date signed: 2-3-48

(Licensed Embalmer's Statement on Reverse Side)

...ED

...ict Health Officer No. 4

...ict File ... 248-174

D... 2-11-48

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 Raymond Crews

Licensed Embalmer No. 3467

P. O. Address Sikeston Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.