

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

32181

State File No. _____
 Registrar's No. 182

W. E. Fouch
 FILED SEP 17 1953

BIRTH NO. _____ REG. DIST. NO. 157 PRIMARY REG. DIST. NO. 3028

1. PLACE OF DEATH a. COUNTY <u>Jasper</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Lorraine</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Carthage</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Miller Greene</u>	
c. LENGTH OF STAY (in this place) <u>6 hr.</u>		d. STREET ADDRESS (If rural, give location) <u>R.F.D. 0550</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>McCune - Brooks Hosp.</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>William</u> b. (Middle) <u>Earl</u> c. (Last) <u>Fouch</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>9-8-1953</u>		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	
8. DATE OF BIRTH <u>11-25-1894</u>		9. AGE (In years last birthday) <u>58</u>		IF UNDER 1 YEAR Days <u>9</u> IF UNDER 1 HRS. Hours <u>13</u> Mins. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Hobton Kansas</u>	
				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	

13a. FATHER'S NAME <u>M. B. Fouch</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Sylvia Fouch</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>320-09-2092</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Sylvia Fouch</u> ADDRESS <u>Miller Mo.</u>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH <u>6 hr</u>
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute Coronary Thrombosis</u>		ANTECEDENT CAUSES			
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.			
		DUE TO (b) _____			
		DUE TO (c) _____			
II. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death. <u>Hypertension, Cholelithiasis</u>			<u>Spec.</u>
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 6-7, 1953, to 9-8, 1953, that I last saw the deceased alive on 9-8, 1953, and that death occurred at 11:30 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Fouch H. Pinner M.D.</u>		23b. ADDRESS <u>121. West 4th Carthage, Mo</u>		23c. DATE SIGNED <u>9-8-53</u>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>9-12-1953</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Golden City</u>	
				24d. LOCATION (City, town, or county) (State) <u>Golden City Mo</u>	

DATE REC'D BY LOCAL REG. <u>9-12-53</u>		REGISTRAR'S SIGNATURE <u>Clayton B. Clinton MD</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Monnie Leman</u> ADDRESS <u>Miller Mo.</u>	
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(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED SEP 16 1953
Jasper County Health Office

County File Number 53-9-753
Date Filed SEP 16 1953

JAN 21 1958

OCT 28 1953

OCT 28 1958

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed: L. R. Leiman

Licensed Embalmer No. 3297

P. O. Address Miller 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.