

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **3839**

BIRTH NO. 1110 MAR 10 1913		REG. DIST. NO. 1	PRIMARY REG. DIST. NO. 3000	Registrar's No. 51
1. PLACE OF DEATH a. COUNTY ADAIR		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY SCOTLAND		
b. CITY OR TOWN KIRKSVILLE		c. LENGTH OF STAY (in this place) 2 DAYS	c. CITY OR TOWN R	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION LAUGHLIN HOSP		e. STREET ADDRESS (If rural, give location) TGBIN TOWNSHIP 1		
3. NAME OF DECEASED (Type or Print) FLOYD M. COUCH		a. (First)	b. (Middle)	c. (Last)
4. DATE OF DEATH FEB 28, 1954		4. DATE OF DEATH (Month) (Day) (Year)		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 7-16-1913	9. AGE (In years last birthday) 40
10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) FARMING		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) ADAIR Co. Mo	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME JOSEPH O. COUCH		13b. MOTHER'S MAIDEN NAME VERNA BRADLEY	14. NAME OF HUSBAND OR WIFE ERMA COUCH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) No		16. SOCIAL SECURITY NO. 486-14-1872	17. INFORMANT'S SIGNATURE OR NAME MEMPHIS	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Chronic Diffuse Glomerulo Nephritis ANTECEDENT CAUSES DUE TO (b) Diabetes Mellitus DUE TO (c) _____ Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Idemia		INTERVAL BETWEEN ONSET AND DEATH 19 yrs
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 200 X		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 Jan 16, 1954 , to Feb 28, 1954 , that I last saw the deceased alive on Feb 28, 1954 , and that death occurred at 9:40 AM , from the causes and on the date stated above.				
23a. SIGNATURE A. J. Rhoads M.D.		23b. ADDRESS Kirkville, Mo		23c. DATE SIGNED 2-1-54
24a. BURIAL, CREMATION, OR REMOVAL (Specify) BURIAL		24b. DATE 3-2-1954	24c. NAME OF CEMETERY OR CREMATORY BIBLE GROVE	24d. LOCATION (City, town, or county) (State) BIBLE GROVE Mo.
DATE REC'D BY LOCAL REG. 3-3-54		REGISTRAR'S SIGNATURE Kate Lambert		25. FUNERAL DIRECTOR'S SIGNATURE W. W. ... ADDRESS Memphis Mo.

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Neal Payne*.....

Licensed Embalmer No. *2550*

P. O. Address *Memphis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.