

**FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-031028**

**FILED VS SEP 8 1959**

Registration District No. 317

Primary Registration District No. 548

Registrar's No. 2366

STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY <u>St. Louis</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Webster Groves</u> Length of stay in lb <u>20 Yrs.</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>239 Reavis Pl.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u> c. CITY OR TOWN <u>Webster Groves</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>239 Reavis Pl.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>EDWARD</u> Middle <u>C.</u> Last <u>COUCH</u>			<b>4. DATE OF DEATH</b> Month <u>9</u> -Day <u>2</u> -Year <u>1959</u>				
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. Married</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>10-12-1884</u>	<b>9. AGE</b> (last birthday) <u>74</u>	IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HR Hours _____ Min. _____		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Maintenance (Ret.)</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Amer. Thermometer Co.</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>Ware Mo.</u>			
<b>12. CITIZEN OF WHAT COUNTRY</b> <u>USA</u>			<b>13a. FATHER'S NAME</b> <u>Thomas J. Couch</u>				
<b>13b. MOTHER'S MAIDEN NAME</b> <u>Henrietta Rogers</u>			<b>14. NAME OF HUSBAND OR WIFE</b> <u>Mamie Couch</u>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>488-01-8339</u>		<b>17. INFORMANT</b> <u>Mrs. E.C. Couch</u> Address <u>239 Reavis Pl.</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO (b) <u>Coronary thrombosis</u> DUE TO (c) <u>arteriosclerosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>2 hours</u> <u>1 year</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Calcific aortic stenosis and insufficiency</u>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)				
<b>20c. TIME OF INJURY</b> Hour _____ Month, Day, Year _____							
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE			
<b>21. I attended the deceased from</b> <u>Jan. 14, 1956</u> to <u>Sept. 2, 1959</u> and last saw him alive on <u>Aug 10, 1959</u> Death occurred at <u>8:30 a.m.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> (Degree or title) <u>Joseph W. Edwards M.D.</u>			<b>22b. ADDRESS</b> <u>3720 Washington Blv. St. Louis Mo.</u>		<b>22c. DATE SIGNED</b> <u>8/3/59</u>		
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE</b> <u>9-4-1959</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Oak Hill Cemetery</u>		<b>23d. LOCATION</b> (City, town, or county) (State) <u>Kirkwood Mo.</u>		
<b>24. FUNERAL DIRECTOR</b> <u>Parker-Aldrich Webster Groves Mo.</u> ADDRESS			<b>25. DATE RECD. BY LOCAL REG.</b> <u>9-3-59</u>	<b>26. REGISTRAR'S SIGNATURE</b> <u>John C. Murphy M.D.</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Leslie Welch

Licensed Embalmer No. 4395  
P. O. Address Palmer, Gro

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.