

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Missouri</b>		Length of stay in 1b -----	c. CITY OR TOWN <b>Woodson Terrace</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>9236 Corregidor Drive,</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) <b>MILTON R. COUCH</b>			4. DATE OF DEATH Month Day Year <b>FEBRUARY 20, 1960</b>				
First	Middle		Last	Month	Day		Year

5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>9-9-04</b>	9. AGE (last birthday) <b>55</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Yeast</b>	11. BIRTHPLACE (City and state or country) <b>Houston, Illinois</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>Milton Couch</b>	13b. MOTHER'S MAIDEN NAME <b>Martha E. Gallagher</b>	14. NAME OF HUSBAND OR WIFE <b>Janet Couch</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes World War # 2</b>	16. SOCIAL SECURITY NO. <b>342-09-3943</b>	17. INFORMANT <b>Janet Couch, 9236 Corregidor Dr., 34</b>	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b>		<b>11 days</b>
DUE TO (b) <b>Arteriosclerotic Heart Disease</b>		<b>5 years</b>
DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
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21. I attended the deceased from <b>1954</b> , to <b>2/20/60</b> and last saw <sup>him</sup> <del>her</del> alive on <b>2/20/60</b>	
Death occurred at <b>3:20 a.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.	

22a. SIGNATURE <i>FR Bradley</i>	(Degree or title) <b>M. D.</b>	22b. ADDRESS <b>BARNES HOSPITAL</b>	22c. DATE SIGNED <b>2/20/60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>2-22-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mount Lebanon Cemetery</b>	23d. LOCATION (City, town, or county) <b>St. Louis Co., Missouri</b>
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24. FUNERAL DIRECTOR <b>CALVIN F. FEUTZ</b>	ADDRESS <b>4828 Natural Bridge Blvd., FUNERAL HOME, St. Louis, 15, Missouri.</b>	25. DATE RECD. BY LOCAL REG. <b>FFB 22 1960</b>	26. REGISTRAR'S SIGNATURE <i>Roal Smith M D</i>
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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

*Ralph C. Lunde*

Licensed Embalmer No. 4275

P. O. Address Al Lunde

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.