

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 37896
Registrar's No. 9735

Registration District No. _____

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County 2
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
3526 Arsenal St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME Carrie Couch

3. (b) If veteran, name war no 3. (c) Social Security No. no

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Thomas Couch 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased June 22 1862
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>77</u>	<u>4</u>	<u>20</u>	hr. _____ min.

9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER
12. Name Charles Schwind
13. Birthplace Germany
(City, town, or county) (State or foreign country)
14. Maiden name Mary Berg
15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature May Dunbar

(b) Address 3526 Arsenal St.

17. (a) Burial (b) Date thereof Nov. 15, 1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New St. Marcus Cm.

18. (a) Signature of funeral director Weick Bros Und. Co.

(b) Address 2201 S. Grand Bl.

19. (a) NOV 15 1939 (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 1
(c) City or town St. Louis 16
(If outside city or town limits, write "RURAL")
(d) Street No. 3526 Arsenal St.
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOV. day 12
year 1939 hour 7 minute 45 P. M.

21. I hereby certify that I attended the deceased from Nov. 1-17
1937, to Nov. 7, 1939;
that I last saw her alive on Nov. 7, 1939;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Chronic Myocarditis

Due to _____

Due to _____

Other condition Chronic Diffuse Nephritis
(Include pregnancy within 3 months of death)

Major findings: none

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? no
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? 1 (Specify type of place) Means of injury _____

23. Signature Doc P. Engelman (M. D. or other)

Address 3522 Arsenal Date signed 11/15/39

WAIVE CLAIMS—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1 X1811

3542
2-28 PM
Crown

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 Harry A. Stewart

Licensed Embalmer No. 3722

P. O. Address 412 Duchouquette St.

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, above space should be left blank.