

Registration District No. 605 Primary Registration District No. 4-3-59-5804 Registrar's No. 5804

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

1. PLACE OF DEATH:
(a) County New Madrid
(b) City or town Parma
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 30 years, months or days
In this community Thirty years (Specify whether years, months or days)

3. (a) PRINT FULL NAME William M Couch
3. (b) If veteran, name war no 3. (c) Social Security No. no

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Fannie Couch 6. (c) Age of husband or wife if alive 57 years
7. Birth date of deceased USA 1 (Month) USA 1 (Day) 1862 (Year)

8. AGE: Years 79 Months under 1 year Days hr. min. 1

9. Birthplace USA 1 (City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business

MOTHER FATHER
12. Name Unknown
13. Birthplace USA 1 (City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace USA 1 (City, town, or county) (State or foreign country)

16. (a) Informant John W Couch
(b) Address Parma MO

17. (a) Burial (b) Date thereof July 3-42 (Month) (Day) (Year)
(c) Place: burial or cremation Parma Cemetery

18. (a) Signature of funeral director Thomas C. Kelight
(b) Address Parma MO

19. (a) July 6 1942 (Date received local registrar) (b) ms. S. Stademare (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County New Madrid
(c) City or town Parma (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 2 year 1942 hour 4 minute 30 P.M.
21. I hereby certify that I attended the deceased from: 6-24-42 19 to 7-2-42 19
that I last saw him alive on 6-29-42 19 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Apical Degeneration
Due to
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

Duration
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? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? (Specify type of place) (e) Means of injury
23. Signature W. J. Gelbat (M. D. or other) MS
Address Parma MO Date signed 7-2-42

STATEMENT BY LICENSED EMBALMER

not

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 *Thomas C. King*
Licensed Embalmer No. *2189*
P. O. Address *Parsons 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.