

FILED MAR 18 1946

Registration District No. _____

Primary Registration District No. **3000**

Registrar's No. **53**

1. PLACE OF DEATH:

(a) County **ADAIR**
(b) City or town **KIRKSVILLE**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Community Nursing Home**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **No hospital**
(Specify whether years, months or days) **R hours. 4**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Knox 52**
(c) City or town **Edina**
(If outside city or town limits, write "RURAL") **0**
(d) Street No. _____ (If rural, give location) **1**
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

JAMES O COUCHMAN

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex **M.D** 5. Color or race **W:** 6. (a) Single, widowed, married **2 divorced. Widowed**
6. (b) Name of husband or wife **Pearlie W Kresow.** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Aug - 23 - 1875**
(Month) (Day) (Year)

8. AGE: Years **70** Months **5** Days **21** If less than one day _____ hr. _____ min.

9. Birthplace **Scotland, Mo.** (City, town, or county) **Missouri** (State or foreign country)

10. Usual occupation **Day Laborer**

11. Industry or business _____

MOTHER FATHER
12. Name **Michael Couchman**
13. Birthplace **up. Kentucky** (City, town, or county) (State or foreign country)
14. Maiden name **Mary Emma Lester**
15. Birthplace **up. Kentucky** (City, town, or county) (State or foreign country)

16. (a) Informant **Richard L Couchman**
(b) Address **1504 S. Adams, Kirksville, Mo.**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **Feb. 17 - 1946**
(Month) (Day) (Year)

(c) Place: burial or cremation **Lindley Edina Mo.**

18. (a) Signature of funeral director **Keith Hudson**

(b) Address **Edina, Missouri**

19. (a) **2-16-46** (Date received local registrar) (b) **Hate Lambert** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb** day **14**
year **1946** hour **4** minute **00 P.M.**
21. I hereby certify that I attended the deceased from **2:00 P.M. Feb 14**
14 1946 to **4:00 P.M. Feb 14 1946**
that I last saw him alive on **FEB 14** 1946
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage** Duration **hours**

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy **g 20**
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) (c) Means of injury **2**

23. Signature **Geo. F. Dawson** (M.D. or other) **R.H.O.**
Address **Kirksville, Mo** Date signed _____

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

1
3
3

1878

RECEIVED

District Health Officer No. 10

District File Number 3-46-485

Date Filed MAR 15 1946

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

Keith Hudson

Licensed Embalmer No. 2413

P. O. Address. *Edina, Missouri*

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.