

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **38854**

FILED NOV 25 1947

Registration District No. **1957**

Primary Registration District No. **3040**

Registrar's No. **1480**

1. PLACE OF DEATH:

(a) County **Livingston**

(b) City or town **Chillicothe**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
102 East Herriman Street
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **72 years**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Livingston**

(c) City or town **Chillicothe**
(If outside city or town limits, write "RURAL")

(d) Street No. **102 East Herriman**
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME **Parker Allel Couch**

3. (b) If veteran, name war.....

3. (c) Social Security No.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **November** day **10th**
year **1947** hour **10** minute **50 P.** M.

4. Sex **Male**

5. Color or race **White**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Mabel E. Couch**

6. (c) Age of husband or wife if alive **61** years

7. Birth date of deceased: **August 28 1875**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Oct 7** 19**47** to **Nov 10** 19**47**
that I last saw him alive on **Nov 10** 19**47**
and that death occurred on the date and hour stated above

Immediate cause of death **Heart Stomach**

8. AGE:

Years	Months	Days	If less than one day
72	2	12hr.min.

Due to.....

Due to.....

Other conditions.....
(Include pregnancy within 3 months of death)

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

10. Usual occupation **Retired Railroader**

11. Industry or business.....

12. Name **Joel Couch**

13. Birthplace **Tennessee**
(City, town, or county) (State or foreign country)

14. Maiden name **Elizabeth Patterson**

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

PHYSICIAN

Major findings:
Of operations.....

Of autopsy.....

Underline the cause of which death should be charged statistically.

16. (a) Informant **Mrs. Parker A. Couch**
(b) Address **Chillicothe, Missouri**

17. (a) **Burial** (b) Date thereof **11-13-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Edgewood Cemetery**

18. (a) Signature of funeral director **Norman Funeral Home**
(b) Address **Chillicothe, Missouri**

19. (a) **Nov-12-47** (b) **Francis B. Neill**
(Date received local registrar) (Registrar's signature)

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?..... (Specify type of place)

While at work?..... (e) Means of injury.....

23. Signature **E. W. Carpenter** (M. D. or other).....
Address **Chillicothe Mo** Date signed **11/12/47**

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

57
21

MOTHER FATHER

**DISTRICT HEALTH OFFICE
Cameron, Mo.**

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 _____

Licensed Embalmer No. 4036

P. O. Address Chillicothe, 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.