No. 300
10.48

FILED JUL 6 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

20248

State File No.

BIRTH NO. REG. DIST. NO. 209 PRIMARY REG. DIST. NO. 3043 Registrar's No. 209

1. PLACE OF DEATH
a. COUNTY MARION
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) HANNIBAL
c. LENGTH OF STAY (in this place) 2 DAYS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LEVERING HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE MO
b. COUNTY MONROE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) RURAL — JACKSON
d. STREET ADDRESS (If rural, give location) R. F. D. # 1, PARIS

3. NAME OF DECEASED (Type or Print)
a. (First) NETTIE
b. (Middle) FRANCES
c. (Last) COUCH

4. DATE OF DEATH (Month) (Day) (Year) JUNE 23, 1949

5. SEX FEMALE
6. COLOR OR RACE WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED
8. DATE OF BIRTH SEPT 12, 1910
9. AGE (In years last birthday) 38 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME
10b. KIND OF BUSINESS OR INDUSTRY ✓
11. BIRTHPLACE (State or foreign country) RALLS CO., MO.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME BENJ. COUCH
13b. MOTHER'S MAIDEN NAME SUSIE MEADOWS
14. NAME OF HUSBAND OR WIFE ✓

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) ✓
16. SOCIAL SECURITY NO. ✓
17. INFORMANT'S SIGNATURE OR NAME Robert W. Couch ADDRESS PARIS, MO.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Peripheral Vascular Collapse — INTERVAL BETWEEN ONSET AND DEATH: 1 Day

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Myocardial Insufficiency — 3 Days

DUE TO (c) Cyclic Vomiting — 5 Days

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

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19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/21, 1949, to 6/23, 1949, that I last saw the deceased alive on 6/23, 1949, and that death occurred at 5:05 P. m., from the causes and on the date stated above.

23a. SIGNATURE F. E. Sultzman (Degree or title) M. D.
23b. ADDRESS Hannibal Missouri
23c. DATE SIGNED 6/24/49

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
24b. DATE 6-26-49
24c. NAME OF CEMETERY OR CREMATORY WALNUT GROVE
24d. LOCATION (City, town, or county) (State) PARIS, MO.

DATE REC'D BY LOCAL REG. 6-27-49
REGISTRAR'S SIGNATURE By WC Fisher Dr. E. M. Lucke Deputy
25. FUNERAL DIRECTOR'S SIGNATURE Speed & Blakey ADDRESS PARIS, MO.

(Licensed Embalmer's Statement on Reverse Side)

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

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 ..... Student Embalmer No. ....., working under my personal supervision.

Student ..... Student Embalmer

Signed E. H. Agnew

Licensed Embalmer No. 4000

P. O. Address Paris, 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.