

THE DIVISION OF HEALTH - MISSOURI
STANDARD CERTIFICATE OF DEATH

39445

STATE FILE NUMBER

FILED NOV 21 1957

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 269

Health,
& Welfare
S. Public
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v. 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Knox</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fulton</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Rutledge,</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hosp. # 1</u> Length of stay in 1b <u>20 yrs</u>		d. STREET ADDRESS (If outside, give location) <u>052 052</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Earnest</u> Middle <u>(X) Couchman</u> Last <u>Couchman</u>		4. DATE OF DEATH Month <u>11</u> Day <u>10</u> Year <u>1957</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 6, 1884</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Independent</u>	9. AGE (In years last birthday) <u>73</u> IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
11. BIRTHPLACE (City and state or country) <u>Scotland County, Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Michail Couchman</u>		14. MOTHER'S MAIDEN NAME <u>Mary Leslie</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unk.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>unk.</u>	
17. INFORMANT <u>State Hospital No. 1; Fulton, Missouri</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Pneumonia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Pulmonary Emphysema; LBBB</u> DUE TO (c) <u>CNS-Lues c Deterioration</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>026x</u>			INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u>
20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour <u>11</u> Month <u>11</u> Day <u>10</u> Year <u>1957</u> a. m. <u>pm</u>			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from <u>State Hosp. Fulton, Mo</u> <u>Sept-27, 1957</u> to <u>Nov-10, 1957</u> and last saw <u>her</u> alive on <u>Nov-10, 1957</u> Death occurred at <u>11 pm</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Frank Mickiewicz, M.D.</u>		22b. ADDRESS <u>State Hosp. #1, Fulton, Mo.</u>	22c. DATE SIGNED <u>11-10-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>11-14-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>anatomical board</u>	23d. LOCATION (City, town, or county) (State) <u>Columbia Mo</u>
24. FUNERAL DIRECTOR <u>J. O. Roberts</u> ADDRESS <u>Columbia Mo</u>		25. DATE RECD. BY LOCAL REG. <u>Nov. 14-1957</u>	26. REGISTRAR'S SIGNATURE <u>Maretha Lawrence</u>

(Licensed Embalmer's Statement on Reverse Side)

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.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.