

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023892

STATE FILE NUMBER

FILED JUN 16 1959 Registration District No. 360 Primary Registration District No. 3076 Registrar's No. 130

300
1-57

1. PLACE OF DEATH a. COUNTY <u>Vernon</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Vernon</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Nevada</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Bronaugh</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Nevada City Hosp</u>		Length of stay in lb <u>20 DAYS</u>	d. STREET ADDRESS (If outside, give location) <u>1080 R R</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Gilbert</u> Middle <u>Ray</u> Last <u>Couch</u>			4. DATE OF DEATH Month <u>6</u> Day <u>3</u> Year <u>59</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/11/1897</u>	9. AGE (In years from birthday) <u>61</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinest</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (City and state or country) <u>Albany, Mo.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>William T. Couch</u>		13b. MOTHER'S MAIDEN NAME <u>Martha Baker</u>	
14. NAME OF HUSBAND OR WIFE <u>Glessie Couch</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>702-18-2082</u>	
17. INFORMANT <u>Harold Couch,</u>		Address <u>Moab, Utah</u>		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>Cerebral Vascular Accident</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last		DUE TO (b) <u>Acute cardiac decompensation</u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u>	
DUE TO (c) <u>Diabetes Mellitus</u>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetes Mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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 Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <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>Dec. 1954</u> to <u>June 3, 1959</u> and last saw ^{him} her alive on <u>June 3, 1959</u> Death occurred at <u>Nevada, Mo.</u> <u>9:00 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>L. F. McCann</u> L. F. McCann, M. D.			22b. ADDRESS <u>Moore Bldg., Nevada, Missouri</u>		22c. DATE SIGNED <u>6/9/1959</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>6/6/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Deerfield</u>		23d. LOCATION (City, town, or county) (State) <u>Deerfield, Mo.</u>
24. FUNERAL DIRECTOR <u>Richard L. Shorten</u>		ADDRESS <u>Nevada, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>6-12-1959</u>	
26. REGISTRAR'S SIGNATURE <u>Anna E. Perry</u>					

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

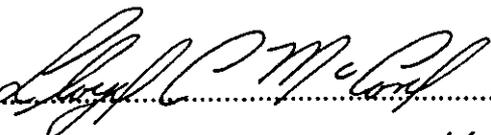
MEDICAL CERTIFICATION

Doctor, coroner, etc.: must use only standard nomenclature in item 16. No symptoms will be treated. All diseases in Part I must be causally related.

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. 4853
P. O. Address Florida, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.