

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-045336

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11552

FILED DEC - 2 1963

VS 300
Rev. 4/59

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USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived) If Institution: Residence before admission) a. STATE		b. COUNTY		c. CITY OR TOWN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
St Louis, Missouri		36 days		Missouri		St Louis		Florissant		Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>					
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
Vets Admin Hospital				Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		1150 Gahan Dr									
3. NAME OF DECEASED (Type or print)			First			Middle			Last			4. DATE OF DEATH			
Melvin			A			Couch						11/21/63			
5. SEX		6. COLOR OR RACE		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HR			
Male		White				5/17/19		44		Months		Days			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (City and state or country)				12. CITIZEN OF WHAT COUNTRY			
Painter								Sikeston, Missouri				USA			
13a. FATHER'S NAME				13b. MOTHER'S MAIDEN NAME				14. NAME OF HUSBAND OR WIFE							
George Couch				Susie Mouser				June Couch							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT				Address			
Yes				WW II				June Couch, wife (see 2 above)							
18. CAUSE OF DEATH (Enter only one cause per line)												INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a)															
Staphylococcal Pneumonia															
DUE TO (b)															
Bronchiogenic Carcinoma with Metastases															
DUE TO (c)															
1621															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)										PART III. If deceased was female was there a pregnancy in last 90 days.					
										<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
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 a.m. p.m.		Month, Day, Year		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	
				10/17/63						St Louis		St Louis		Mo	
21. I attended the deceased from <u>10/17/63</u> to <u>11/21/63</u> and last saw him alive on <u>11/21/63</u>															
Death occurred at <u>9:05 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.															
22a. SIGNATURE (Degree or title)						22b. ADDRESS						22c. DATE SIGNED			
<i>W. Raphael</i> MD						VAH, St Louis, Mo.						11/2/63			
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town, or county) (State)					
Burial				11-24-63		Memorial Park				Sikeston, Missouri					
24. FUNERAL DIRECTOR						ADDRESS		25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE					
Nunlee Funeral Home-Sikeston, Mo.								NOV 22 1963		<i>Paul Smith M.D.</i>					

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 James L. Crason

Licensed Embalmer No. 5168

P. O. Address Millstadt, Ill.

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.