

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 45570  
Registrar's No. 1301

Registration District No. 1000

Primary Registration District No. 1000

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

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St. Joseph  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
St. Joseph's Hospital  
(If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan

(c) City or town St. Joseph  
(If outside city or town limits, write "RURAL")

(d) Street No. 2621 Sacramento  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Susan Mary Coveney

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

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November Day 27th  
year 1943 hour 4 minute A. M.

21. I hereby certify that I attended the deceased from 11-25-43  
to 11-27-43  
that I last saw h. e alive on 11-27, 1943  
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased October 31 1943  
(Month) (Day) (Year)

Immediate cause of death Infectious diarrhoea Duration 3 wks.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

8. AGE: Years Months Days If less than one day

0 0 26 hr. \_\_\_\_\_ min.

9. Birthplace St. Joseph Missouri  
(City, town, or county) (State or foreign country)

Major findings: 119a  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER { 12. Name Lt. Raymond Coveney

FATHER { 13. Birthplace Natick Massachusetts  
(City, town, or county) (State or foreign country)

14. Maiden name Rita Brani

15. Birthplace Marlboro Massachusetts  
(City, town, or county) (State or foreign country)

16. (a) Informant Lt. Raymond Coveney

(b) Address 2621 Sacramento St.

17. (a) Removal (b) Date thereof Nov. 27, '43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Marlboro, Mass.

18. (a) Signature of funeral director Herman W. Sedufaden

(b) Address 1802 Union St.

19. (a) 11-27-43 (b) Rose Herzog  
(Date received local registrar) (Registrar's signature)

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? \_\_\_\_\_

White at work? \_\_\_\_\_ (Specify type of place)

(c) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) \_\_\_\_\_

Address 624 E. Franklin Date signed 11-27-43

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**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.....

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