No. 300
10.48

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

FILED MAR 3 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 4429

BIRTH NO. 48-86615 REG. DIST. NO. 107 PRIMARY REG. DIST. NO. 3019 Registrar's No. 24

1. PLACE OF DEATH
a. COUNTY: Dunklin
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kennett Mo
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): Drumm Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Mo
b. COUNTY: Dunklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Risco Mo
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): JUDIS
b. (Middle): ANN
c. (Last): COVEY

4. DATE OF DEATH (Month) (Day) (Year): Feb 18 1949

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): U
8. DATE OF BIRTH: Dec 8 1948
9. AGE (In years last birthday): If under 1 year: Months 2, Days 10; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Home Risco Mo
12. CITIZEN OF WHAT COUNTRY?:

13a. FATHER'S NAME: Floyd Covey
13b. MOTHER'S MAIDEN NAME: Grace Covey
14. NAME OF HUSBAND OR WIFE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): ✓
(If yes, give war or dates of service): ✓
16. SOCIAL SECURITY NO.: ✓
17. INFORMANT'S SIGNATURE OR NAME: Floyd Covey
ADDRESS: Risco 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): Varicos Pneumonia — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES

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

DUE TO (b):

DUE TO (c): 492X

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Acute otitis media

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* 2-16, 1949, *to* 2-18, 1949, *that I last saw the deceased alive on* 2-18, 1949, *and that death occurred at* 8:10 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): L. C. Wilson MD
23b. ADDRESS: Kennett Mo
23c. DATE SIGNED: 2-18-49

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 2/19/1949.
24c. NAME OF CEMETERY OR CREMATORY: Haynes
24d. LOCATION (City, town, or county) (State):

DATE REC'D BY LOCAL REG.: Feb 21-49
REGISTRAR'S SIGNATURE: Carl Hubbard
25. FUNERAL DIRECTOR'S SIGNATURE: Emison & Son
ADDRESS: Jonesboro Ark

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No
District File Number 249
Date Filed 9-28-

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.....

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.