

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 7726

FILED MAR 24 1949

BIRTH NO. _____		REG. DIST. NO. <u>71</u>		PRIMARY REG. DIST. NO. <u>3012</u>		Registrar's No. <u>26</u>	
1. PLACE OF DEATH a. COUNTY <u>CLAY</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <u>MISSOURI</u> b. COUNTY <u>CLAY</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>EXCELSIOR SPRINGS</u>		c. LENGTH OF STAY (in this place) <u>3 DAYS</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>EXCELSIOR SPRINGS</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>EXCELSIOR SPRINGS HOSPITAL</u>				d. STREET ADDRESS (If rural, give location) <u>334 FOLEY STREET</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>REBECCA</u> b. (Middle) <u>ANGELINE</u> c. (Last) <u>COVEY</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>FEB. 21, 1949</u>				
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>		8. DATE OF BIRTH <u>AUG. 4, 1864</u>	
9. AGE (In years last birthday) <u>84</u>		IF UNDER 1 YEAR Months <u>6</u> Days <u>17</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>TENNESSEE</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>JOHN SWAFFORD</u>			13b. MOTHER'S MAIDEN NAME <u>NANCY SHIRLEY</u>		14. NAME OF HUSBAND OR WIFE <u>ANDREW W. COVEY</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Mike Mallett 444 S. Main Mo.</u>			
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Gastrointestinal hemorrhage</u>					INTERVAL BETWEEN ONSET AND DEATH <u>30 hrs</u>
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Acute cardiac decompensation 1 wk</u> DUE TO (c) <u>Cardiovascular renal disease</u>					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Arteriosclerosis, Avitaminosis</u>					<u>442</u>
19a. DATE OF OPERATION <u>none</u>		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>18 Jan, 1949</u> , to <u>21 Feb, 1949</u> , that I last saw the deceased alive on <u>20 Feb, 1949</u> , and that death occurred at <u>2:40 am.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>George E. Sanders M.D.</u>				23b. ADDRESS <u>Excelsior Springs, Mo.</u>		23c. DATE SIGNED <u>21 Feb '49</u>	
24a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>FEB. 23, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>PISGAH</u>		24d. LOCATION (City, town, or county) (State) <u>4 mi. E. Excelsior Springs, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>2/21/49</u>		REGISTRAR'S SIGNATURE <u>Baroline Hutchings</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Claude Grichard, Excelsior Spgs, Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 3-23-49

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

E. E. White

Licensed Embalmer No. 4168

P. O. Address Exelsior Springs, 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 this body is not embalmed, fact should be so stated above.