

MOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-046191

STATE FILE NUMBER

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **12198**

AMENDED

FILED JAN 5 1962

1. PLACE OF DEATH a. COUNTY 2 yrs.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
Length of stay in 1b 91 mo. 24 days		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Chronic Hosp.		d. STREET ADDRESS (If outside, give location) 5800 Arsenal St.	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Cora Middle Maye Last Covert			4. DATE OF DEATH Month 12 Day 25 Year 61		
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5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12-26-74	9. AGE (last birthday) 86	IF UNDER 1 YEAR Months 11 Days 30	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Ohio	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Edward Joseph Covert	13b. MOTHER'S MAIDEN NAME Mary Henderson	14. NAME OF HUSBAND OR WIFE None
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Address Mrs. S. B. Philpot, 608 Kingsland Ave.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Encephalomalacia, Rt Cerebrum		5 weeks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Thrombosis of mid-cerebral artery	5 weeks
	DUE TO (c) Atherosclerosis 332x	Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Arteriosclerotic heart disease		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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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.)
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20c. TIME OF INJURY Hour a.m. p.m. 	Month, Day, Year
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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
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21. I attended the deceased from **2-3-59** to **12-25-61** and last saw her/him alive on **12-25-61**
Death occurred at **5:50 a.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Deedee or title) Kenneth Chase MD	22b. ADDRESS 5800 Arsenal St.	22c. DATE SIGNED 12/26/61
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23a. BURIAL CREMATION, REMOVAL (Specify) Removal	23b. DATE Dec. 29, 1961	23c. NAME OF CEMETERY OR CREMATORY Cumberland Cemetery	23d. LOCATION (City, town, or county) (State) Cumberland, Ohio
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24. FUNERAL DIRECTOR ADDRESS Ambruster Mortuary, 6633 Clayton Rd.	25. DATE RECD. BY LOCAL REG. DEC 27 1961	26. REGISTRAR'S SIGNATURE Paul Smith M.D.
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DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FILE NO. - SHOULD READ

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 *Fred J. James*

Licensed Embalmer No. 4788

P. O. Address St. Louis

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.