

147

147

147

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Lawrence Registration District No. 467 File No. _____
 Township _____ Primary Registration District No. 4280 Registered No. 191
 City Aurora (No. _____) St. _____ Ward _____

2. FULL NAME

J. Melvin Covey
 (a) Residence. No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Wid

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Cora Covey

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 29

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
53 unable to read

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer R. P. Bealy

9. BIRTHPLACE (CITY OR TOWN) Ark.
 (STATE OR COUNTRY)

10. NAME OF FATHER John Covey

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ark.
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER James Thompson

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ark.
 (STATE OR COUNTRY)

14. INFORMANT Jim Ballard
 (Address) Aurora Mo.

15. FILED 4-1, 1930 W. W. [Signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 11 1930

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him _____, _____, _____, 19____, and that death occurred, on the date stated above, at _____, 1:30 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Heart failure
 (duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTORY (SECONDARY) Probly. Indigestion
 (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? D. L. Patton Coroner
 (Signed) _____, M. D.

, 19 (Address) Aurora Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Smoyville, Ark DATE OF BURIAL 3-13 19 30

20. UNDERTAKER McCals Bros Southwest City Mo. ADDRESS _____

FIVE A FEE FOR CERTIFICATES UNTIL 7 ARE COMPLETE AS PRESCRIBED BY LAW REGISTRARS SHALL

SUPPLEMENTARY

5-9320