

FILED AUG 7 1948

Registration District No. _____

Primary Registration District No. **4125**

Registrar's No. **34**

1. PLACE OF DEATH:
 (a) County **Clark**
 (b) City or town **Revere**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **1**
(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 **Clark** **23**
 (c) City or town **Revere** **3**
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) Citizen of foreign country? **no** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **Rose Emma Corvert**
 3. (b) If veteran, name war
 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **June** day **22**
 year **1948** hour **10** minute **15 P.** M.
21. I hereby certify that I attended the deceased from **June 10-1948**
 _____, 19____ to **June 22**, 19**48**
 that I last saw him alive on **June 22**, 19**48**
 and that death occurred on the date and hour stated above.

4. Sex **F.M.** 5. Color or race **W.** 6. (a) Single, widowed, married, divorced **widowed**
 6. (c) Age of husband or wife if alive years
 7. Birth date of deceased **April - 13 - 1877**
(Month) (Day) (Year)

Immediate cause of death _____
Coronary Artery **1948**
 Due to _____
 Due to _____

8. AGE: Years **71** Months **2** Days **9**
 If less than one day _____ hr. _____ min.

9. Birthplace **Athena Clark County Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **at Home**

MOTHER FATHER
 11. Industry or business _____
 12. Name **S. W. M. Doctor**
 13. Birthplace **Virginia**
(City, town, or county) (State or foreign country)
 14. Maiden name **Dorothy Ann Cardinal**
 15. Birthplace **Not Known**
(City, town, or county) (State or foreign country)

Other conditions (include pregnancy within 3 months of death) _____
 Major findings: **HIV**
 Of operations _____
 Of autopsy _____

16. (a) Informant **Mrs. Bernice Caravichian**
 (b) Address **Green Bay Wisconsin**
 17. (a) **Burial** (b) Date thereof **6-24-48**
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Revere Mo. Cemetery**

22. 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? _____

18. (a) Signature of funeral director **Frank J. Karle**
 (b) Address **Kokota Mo.**
 19. (a) **8/4-48** (b) **J. P. Bridges**
(Date received local registrar) (Registrar's signature)

While at work? _____
(Specify type of place) (Means of injury)
 23. Signature **J. P. Bridges** (M. D. or other) _____
 Address **Revere Mo.** Date signed **8/24/48**

RECEIVED

District Health Officer No.

District File Number 8-46

Date Filed AUG 6 - 1948

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.....

Fred J. Karle

Licensed Embalmer No. 1023

P. O. Address Kalioke Ull

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

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

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Aug
Registrar's No. 37

Registration District No. 70

Primary Registration District No. 4125

1. PLACE OF DEATH:

(a) County Clark
(b) City or town Revere
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Rose E. Coover

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color W 6. (a) Single, widowed, married, divorced Wed
race _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased April 18 (Month) (Day) (Year)

8. AGE: Years 71 Months _____ Days _____ (If less than one day) _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country) No

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____
(b) Address _____
17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal) (Specify type of place)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____
19. (a) 8/11-18 (b) J. Bridges
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Year 1942 Hour _____ minute _____ M. 2

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.
Immediate cause of death _____ Duration _____

Due to _____
Due to _____
Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____ PHYSICIAN _____
Of autopsy _____ Underline the cause to which death should be charged statistically.

22. 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? _____
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

22546