

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED FEB 26 1953

State File No. **7452**  
Registrar's No. **1678**

**318**      **1003**

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		State File No. <b>7452</b>		Registrar's No. <b>1678</b>			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY _____							
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>				c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>					
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Homer G Phillips Hospital</b>				d. STREET ADDRESS (If rural, give location) <b>2409 N Sarah</b>							
3. NAME OF DECEASED (Type or Print) a. (First) <b>Theodore</b>			b. (Middle) _____			c. (Last) <b>Covington</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Feb 8 1953</b>		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Cauc</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>		8. DATE OF BIRTH <b>Jan 6 1900</b>		9. AGE (In years last birthday) <b>53</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <b>N.C.</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
13a. FATHER'S NAME <b>Not known</b>			13b. MOTHER'S MAIDEN NAME <b>Not known</b>			14. NAME OF HUSBAND OR WIFE <b>Olevia Covington</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <b>Olevia Covington</b> ADDRESS <b>2409 N. Sarah</b>						
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, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Congestive Heart Failure</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Undetermined</b>  DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>None</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Undet.</b>	
19a. DATE OF OPERATION _____			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? <b>4341</b>						
22. I hereby certify that I attended the deceased from <b>2-7</b> , 19 <b>53</b> , to <b>2-8</b> , 19 <b>53</b> , that I last saw the deceased <b>alive on 2-8</b> , 19 <b>53</b> , and that death occurred at <b>7:05p</b> m., from the causes and on the date stated above.											
23. SIGNATURE <b>Edw B Williams</b> (Degree or title) <b>M. D.</b>				23b. ADDRESS <b>2601 N Whittier St</b>				23c. DATE SIGNED <b>2-10-53</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>2-14-53</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Washington Park</b>		24d. LOCATION (City, town, or county) (State) <b>St Louis MO</b>					
DATE REC'D BY LOCAL REG. <b>FEB 13 1953</b>		REGISTRAR'S SIGNATURE <b>J Carl Smith</b>			25. FUNERAL DIRECTOR'S SIGNATURE <b>A L Beard</b> ADDRESS <b>4303 Delmar</b>						

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

(Licensed Embalmer's Statement on Reverse Side)

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 *Leroy G. Bannister*

Licensed Embalmer No. *4523*

P. O. Address *3880 Easton Ave*

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.