

UNITED STATES DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-041315

FILED VS NOV 30 1959

STATE FILE NUMBER

Registration District No. 290 Primary Registration District No. _____ Registrar's No. 136

ENDED
12-7-59
Undetermined, awaiting tests
DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF attending physician
18 I(b) Rabies

1. PLACE OF DEATH a. COUNTY Pulaski			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Georgia b. COUNTY Dekalb		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Fort Leonard Wood		Length of stay in 1b	c. CITY OR TOWN Decatur		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION US Army Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 252 Adair St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Reginald Allen Covington			4. DATE OF DEATH Month November Day 14 Year 1959		
5. SEX Male	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 3rd May 36	9. AGE (last birthday) 23	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier		10b. KIND OF BUSINESS OR INDUSTRY U.S. Army	11. BIRTHPLACE (City and state or country) Decatur Georgia	12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Deceased		13b. MOTHER'S MAIDEN NAME Mattie (Unknown)	14. NAME OF HUSBAND OR WIFE ----		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. 7 Nov. 1958	17. INFORMANT Hugh W Ellis CWO AOD Address U.S. Army Hospital Ft Leonard Wood Mo.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Cardiac arrest Rabies DUE TO (b) Undetermined Awaiting Further Laborty Tests DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____		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
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at 1345 hrs 14 Nov 1959 _____ m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE H. Baruch Capt MC (Degree or title)			22b. ADDRESS US Army Hospital Ft Leonard Wood Mo.		22c. DATE SIGNED 11-14-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE unknown	23c. NAME OF CEMETERY OR CREMATORY Decatur	23d. LOCATION (City, town, or county) Decatur	23e. STATE Georgia	
24. FUNERAL DIRECTOR D. Shadel ADDRESS Lebanon Mo.		25. DATE RECD. BY LOCAL REG. 11-17-1959	26. REGISTRAR'S SIGNATURE Eula Mae Anderson		

City _____ State _____
County _____
Date _____

Age _____ Sex _____
Race _____

Place of death _____
Cause of death _____

Time of death _____
Place of burial _____

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 R.W. Parker

Licensed Embalmer No. 3848

P. O. Address Mt. Pleasant, 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 embalmed by a **STUDENT**, he also shall sign in his **OWN** handwriting.
If this body is not embalmed, fact should be so stated above.