

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-020796

FILED VS MAY 25 1960

318

1003

5203

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Kentucky b. COUNTY Hancock			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		Length of stay in 1b 3 Wks		c. CITY OR TOWN Lewisport		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Rt. # 3		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle A. Last COVETTS				4. DATE OF DEATH Month MAY Day 13 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 3/6/1902	9. AGE (last birthday) 58	IF UNDER 1 YEAR Months 5 Days 13	IF UNDER 24 HR Hours 13 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Housework		11. BIRTHPLACE (City and state or country) Lewisport, Kentucky		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME James W. Williams			13b. MOTHER'S MAIDEN NAME Alice Williams		14. NAME OF HUSBAND OR WIFE Frank C. Covetts		
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. Nil.		17. INFORMANT Address Mrs. Merl Chapman, Lewisport, Kentucky.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain Tumor - Right Frontal Lobe						INTERVAL BETWEEN ONSET AND DEATH 5 months	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____						193.0	
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 checked="" 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	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 APRIL 26, 1960 to MAY 13, 1960 and last saw her/him alive on MAY 13, 1960 Death occurred at 10:43 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) FR Bradley				22b. ADDRESS BARNES HOSPITAL		22c. DATE SIGNED 5/14/60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 5-16-60	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) Lewisport, Ky.		(State)
24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe Inc., 4700 Washington, Blvd.				25. DATE RECD. BY LOCAL REG. MAY 17 1960		26. REGISTRAR'S SIGNATURE Roald Smith, M.D.	

DOCUMENT

MEDICAL CERTIFICATION

Subscribed and sworn to before me on this day of May 1960 by AFFIDAVIT OF

AUG 23 1960

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body, whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Harvey Kahle

Licensed Embalmer No. 4596

P. O. Address St Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.