

318

1003

3054

STATE FILE NUMBER

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

AMENDED

FILED APR 14 1961

DATE AMENDED

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b	c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Jewish Hospital		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 5337 Winona Ave.
			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last WARREN S. COVINGTON			4. DATE OF DEATH Month Day Year Mar. 31 1961			
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6-1-1892	9. AGE (last birthday) 68	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk (Retired) City of St. Louis		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) DeSoto, Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Winifred S. Covington		13b. MOTHER'S MAIDEN NAME Adelia Cole		14. NAME OF HUSBAND OR WIFE Edna W. Covington		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO.	17. INFORMANT Address Edna W. Covington 5337 Winona Ave.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Gangrene of entire small bowel & rt. colon (peritonitis)</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>
DUE TO (b) <i>Embolism of Superior Mesenteric Artery</i>		<i>Same</i>
DUE TO (c) <i>Auricular Fibrillation 2 days to A.S.H.D</i>		<i>2 years.</i>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Generalized arteriosclerosis - Cerebral, coronary, peripheral</i>		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
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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.) <i>420.0</i>
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20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year
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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
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21. I attended the deceased from *March 30* to *Mar 31* and last saw him alive on *March 30 (Midnite)*
Death occurred at *6:00 A.* m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>Richard G. Sisson MD</i>		22b. ADDRESS <i>4652 Maryland - St. L 8</i>	22c. DATE SIGNED <i>3/31/61</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal (Mtr)</i>	23b. DATE <i>Apr. 3, 1961</i>	23c. NAME OF CEMETERY OR CREMATORY <i>City Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>Fulton, Mo.</i>
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24. FUNERAL DIRECTOR <i>Kriegshauser</i>	ADDRESS <i>4228 S. Kingshighway Blvd.</i>	25. DATE RECD. BY LOCAL REG. <i>MAR 31 1961</i>	26. REGISTRAR'S SIGNATURE <i>Roal Smith, M.D.</i>
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INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

Admitted to hosp 3/29/61 by Dr. Sisson

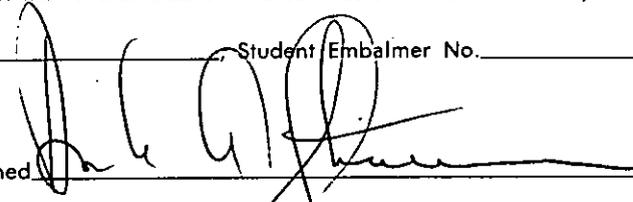
SHOULD READ

BY AFFIDAVIT OF

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  _____

Licensed Embalmer No. 4533

P. O. Address _____

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.