S. No. 2
DM—2-43
v. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 22911

FILED JUL 21 1944

Registration District No. 318

Primary Registration District No.

Registrar's No. 6211

1. PLACE OF DEATH:

(a) County

(b) City or town St Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
4646 Page Av
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution
(Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 1003 94

(a) State Mo (b) County St Francois

(c) City or town Bonne Terre
(If outside city or town limits, write "RURAL")

(d) Street No. 310 So Spruce St
(If rural, give location) R. R.

(e) Citizen of foreign country? (Yes or No)
If yes, name country /

3. (a) PRINT FULL NAME Reed Covington

3. (b) If veteran, name war None

3. (c) Social Security No None

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Bessie

6. (c) Age of husband or wife if alive 67 years

7. Birth date of deceased Aug (Month) 23 (Day) 1876 (Year)

8. AGE: Years 67 | Months 10 | Days 19 | If less than one day ____hr. ____min.

9. Birthplace Bonne Terre Mo (City, town, or county) O (State or foreign country)

10. Usual occupation Retired Custodian

11. Industry or business

FATHER
12. Name Joseph Covington
13. Birthplace Unk Kentucky (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Hulda Fraser
15. Birthplace Unk (City, town, or county) 9 (State or foreign country)

16. (a) Informant Bessie Covington
(b) Address 310 So Spruce Bonne Terre Mo

17. (a) Burial (Burial, cremation, or removal) Bonne Terre Mo (b) Date thereof 7-16-44 (Month) (Day) (Year)

(c) Place: burial or cremation Bonne Terre, Mo.

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4704 Washington Av

19. (a) JUL 12 1944 (Date received local registrar) (b) J. F. Bruenk (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 12
year 1944 hour 2 minute A M.

21. I hereby certify that I attended the deceased from March 9, 1944, to July 12, 1944, that I last saw h[illegible] alive on July 12, 1944, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Pneumonia, Bronch	3 days
Due to Cerebral Hemorrhage	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy None

PHYSICIAN

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Albert H Coughlin (M. D. or other)

Address 457 N Kingshighway Date signed

84 (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.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed.....

Licensed Embalmer No.....2971.....

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