

JAN 15 1941 791

Registration District No. _____ Primary Registration District No. **1003** Registrar's No. _____

1. PLACE OF DEATH:
(a) County **St Louis** **2**
(b) City or town **St Louis**
(c) Name of hospital or institution:
3944 Delmar
(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)

3. (a) PRINT FULL NAME **JAMES F. CODY**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **M** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Nellie Cody** 6. (c) Age of husband or wife if alive **70** years
7. Birth date of deceased **May 11 1873**
(Month) (Day) (Year)

8. AGE: Years **67** Months **6** Days **-** If less than one day _____ hr. _____ min.

9. Birthplace **Ireland St. Louis**
(City, town, or county) (State or foreign country)

10. Usual occupation **Paper Hanger**

11. Industry or business _____
12. Name **James F. Cody**
13. Birthplace **Ireland**
(City, town, or county) (State or foreign country)
14. Maiden name **Mary Mansfield**
15. Birthplace **Ireland**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Nellie Cody**
(b) Address **3944 Delmar**

17. (a) **Calvary** (b) Date thereof **Dec 5-1940**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Calvary**

18. (a) Signature of funeral director **John O. Collins & Co**
(b) Address **928 N. Grand**

19. (a) **DEC 4 1940** (b) **J. H. Bredeck**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo** (b) County **St Louis**
(c) City or town **St Louis** **19**
(If outside city or town limits, write "RURAL")
(d) Street No. **3944 Delmar**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Dec** day **2**
year **1940** hour **8:00 PM** minute _____ M.
21. I hereby certify that I attended the deceased from **11-20-**
19**40** to **Dec 2** 19**40**
that I last saw him alive on **Dec 2** 19**40**
and that death occurred on the date and hour stated above.

Immediate cause of death **Acute Myocardial infarction caused by chronic bronchitis.**
Due to **Chronic Bronchitis** years _____

Due to _____
Other conditions **Paralysis of legs**
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy **106**

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 _____ (a) Means of injury _____
23. Signature **Justus E. Jacobs** (M. D. or other) _____
Address **St. Louis** Date signed **12/2/40**

Duration _____
Underline the cause to which death should be charged statistically

WHITE PENCIL—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1-219511

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..... *Guy W Wilkin*
Licensed Embalmer No..... *3575*
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, above space should be left blank.