

S. No. 2
M-8-13
v. 5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED AUG 3 1945

State File No. 21696

Registration District No. 818

Primary Registration District No. 1003

Registrar's No. 6417

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:
Jewish Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
In this community.....
years, months or days)

3. (a) PRINT FULL NAME Julia Mary Bode

3. (b) If veteran, name war..... No.
3. (c) Social Security No. None

4. Sex Female / 5. Color or race White / 6. (a) Single, widowed, married, divorced Married

(b) Name of husband or wife.....
Theodore H. H. Bode, 6. (c) Age of husband or wife if alive 62 years

7. Birth date of deceased March 6, 1875
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
70 4 18 hr. min.

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

10. Usual occupation At home

11. Industry or business Housewife

12. Name William Cady

13. Birthplace Ireland
(City, town, or county) (State or foreign country)

14. Maiden name.....
15. Birthplace Ireland
(City, town, or county) (State or foreign country)

16. (a) Informant Theodore H. Bode,

(b) Address 6211 Morgandford Rd.

17. (a) Burial (b) Date thereof 7/26/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director. Robert J. Ambruster

(b) Address Clayton Rd. at Concordia Lane

19. (a) Jul 24 1945 (b) J. F. Bredbeck
(Date filed for burial) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County.....
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 6211 Morgandford
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July, day 24
year 1945 hour 1 minute 0 M.

21. I hereby certify that I attended the deceased from July 18 to July 24, 1945
and that death occurred on the date and hour stated above.
that I last saw her alive on July 24, 1945

Immediate cause of death:
Cardiac Decompensation
Pulmonary Atelectasia
Coronary Sclerosis
Due to.....
Hypertensive-Arterio-
Sclerotic C-V Disease
Due to.....
Other conditions: Diabetes Mellitus
(Include pregnancy within 3 months of death)

Duration
6 mo
Yrs
Yrs
Yrs

Major findings:
Of operations.....
Of autopsy: Coronary Sclerosis
Cardiac Decompensation

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?.....
While at work?..... (Specify type of place) (e) Means of injury.....
23. Signature Thomas Buehler (M.D. or other)
Address Jewish Hospital Date signed 7/24/45

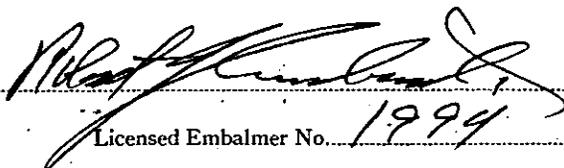
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

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.....

1999

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.