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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

21780

FILED JUL 28 1945 STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. _____

Primary Registration District, No. _____

1003

Registrar's No. _____

318

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:
City Hospital 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 hrs
In this community Life (Specify whether years, months or days)

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. 3119 So. Broadway
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Elsie Cody

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

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

6. (b) Name of husband or wife Michael Cody 6. (c) Age of husband or wife if alive 67 years

7. Birth date of deceased Jan 27 1872
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
73 5 23 hr. min.

9. Birthplace Manchester Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER { 12. Name Unknown
FATHER { 13. Birthplace Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Michael Cody
(b) Address 3119 So. Broadway, St. Louis, Mo.

17. (a) Burial (b) Date thereof 7/24/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Matthews Cemetery, St. Louis

18. (a) Signature of funeral director A. W. McLaughlin
(b) Address 2301 Lafayette Ave. St. Louis Mo.

19. (a) JUL 21 1945 (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 20
year 1945 hour 2 minute 38 P.M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw h _____ alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death _____
Supraventricular tachycardia

Due to Senility

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy _____

Duration

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? Louis

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature Dr. Alfred J. Berry (M. D. or other) _____

Address: Deputy Coroner Date signed 7-21-45

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

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

L. R. Cooper

Licensed Embalmer No. *3633*

P. O. Address *2317 Lafayette*

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. AugRegistrar's No. 1306Registration District No. 318Primary Registration District No. 1003

1. PLACE OF DEATH:

- (a) County.....
 (b) City or town..... St. Louis
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 (c) Name of hospital or institution:

(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 Elsie Cody

3. (b) If veteran, name war..... 3. (c) Social Security No.

4. Sex
- F
5. Color or race
- w
6. (a) Single, widowed, married, divorced
- m

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if

7. Birth date of deceased.....
-
- (Month) (Day) (Year)

8. AGE: Years
- 73
- Months Days If less than one day
-
- hr. min.

9. Birthplace.....
-
- (City, town, or county) (State or foreign country)
- mo

10. Usual occupation

11. Industry or business

- MOTHER FATHER { 12. Name.....
 13. Birthplace..... (City, town, or county) (State or foreign country)
 14. Maiden name.....
 15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant.....
-
- (b) Address.....

17. (a) (Burial, cremation, or removal) (b) Date thereof.....
-
- (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a)
- AUG 1 1945
- (Date received local registrar)
- J. F. Bradeck
- (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State..... (b) County.....
 (c) City or town.....
 (If outside city or town limits, write "RURAL")

- (d) Street No..... (If rural, give location)

- (e) Citizen of foreign country?..... (Yes or No)

If yes, name country.....

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-
- year
- 1945
- hour..... minute..... M.

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(Include pregnancy within 3 months of death)

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Underline
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 (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..... (M. D. or other)

Address..... Date signed.....

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

SUPPLEMENTARY

1945

S-21780