

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

13848

State File No.

S. No. 300
v. 10.48

FILED APR 20 1953 BIRTH NO. REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 392

1396

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

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, write RURAL and give town) Springfield		c. CITY (If outside corporate limits, write RURAL and give township) Springfield 1396	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) 2235 N. Benton 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Johns Hospital			
3. NAME OF DECEASED (Type or Print) a. (First) MARTIN		b. (Middle) CODAY	
c. (Last) CODAY		4. DATE OF DEATH (Month) (Day) (Year) April 15 1953	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 21 Sept. 1892
9. AGE (in years last birthday) 60		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	
11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Harvey Coday		13b. MOTHER'S MAIDEN NAME Cora Miller	
14. NAME OF HUSBAND OR WIFE Agnes Coday			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT'S SIGNATURE OR NAME Agnes Coday		ADDRESS Springfield, Mo.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ruptured of Ventricle ANTECEDENT CAUSES Infarction of myocardium DUE TO (b) AS at disease DUE TO (c) Diabetes mellitus II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
INTERVAL BETWEEN ONSET AND DEATH 2 days		Interval between onset and death unknown	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 4200	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR			
22. I hereby certify that I attended the deceased from 4-13 , 1953, to 4-15 , 1953, that I last saw the deceased alive on 4-15 , 1953, and that death occurred at 10:30A. , from the causes and on the date stated above.			
23a. SIGNATURE Howard C. Marshall, M.D. (Degree or title)		23b. ADDRESS Professional Bldg.	
23c. DATE SIGNED 4-15-53			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 4-20-53	
24c. NAME OF CEMETERY OR CREMATORY National Cemetery		24d. LOCATION (City, town, or county) (State) Springfield Missouri	
DATE REC'D BY LOCAL REG. 4-18-53		REGISTRAR'S SIGNATURE Edith Williamson Deputy Reg.	
25. FUNERAL DIRECTOR'S SIGNATURE J.W. KLINGNER & CO.		ADDRESS Springfield, Mo.	

APR 23 1953

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
Student Embalmer

Signed Ogblone Jr.

Licensed Embalmer No. 4126

P. O. Address Springfield

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.