

Registration District No. **791**

Primary Registration District No. **1003**

Registrar's No.

1. PLACE OF DEATH:

(a) County _____
 (b) City or town **St. Louis, Missouri**
(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 **7 Days**
(Specify whether years, months or days)
 In this community **1**

3. (a) PRINT FULL NAME **Della Coady Coady**

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**

6. (b) Name of husband or wife **Guy Coady** 6. (c) Age of husband or wife if alive **45** years

7. Birth date of deceased **Sept. 19 1901**
(Month) (Day) (Year)

8. AGE: Years **38** Months **10** Days **6** If less than one day
 hr. min.

9. Birthplace **Miami Oklahoma**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____

12. Name **Henry Harmon**

13. Birthplace **Racine Missouri**
(City, town, or county) (State or foreign country)

14. Maiden name **Belle Adams**

15. Birthplace **Racine Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mr. Guy Coady**

(b) Address **4252 West Pine Blvd.**

17. (a) **Removal** (b) Date thereof **7-25-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Miami, Okla.**

18. (a) Signature of funeral director **Albert H. Hoppe**

(b) Address **4700 Washington Ave.**

19. (a) **JUL 25 1940** (b) **J. F. Brudeck**
(Date received local registrar) (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. **4252 West Pine Blvd.**
(If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **25**,
 year **1940** hour **4:15** minute _____ A. M.

21. I hereby certify that I attended the deceased from **July 19, 1940** to **July 25, 1940**,
 that I last saw her alive on **July 25, 1940**,
 and that death occurred on the date and hour stated above.

Immediate cause of death
Syphilis of Central Nervous System year

Due to _____

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? _____

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

23. Signature **Walter Ford** (M. D. or other) _____

Address **1515 Lafayette** Date signed **7/25/40**

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 *Albert G. Koffe*

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

23798

State File No. _____

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 191

Primary Registration District No. 1003

Registrar's No. 6243

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

1. PLACE OF DEATH:

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

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) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Della (Coady) Godsey

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 Guy Coady

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

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

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

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name PELLA COADY
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) _____ (b) Date thereof: (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 12/5/40 (b) J. F. Brudeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 28
year _____ hour _____ minute _____ 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 _____
Due to _____
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? _____

While at work _____ (Specify name of place)
(c) Means of injury _____

23. Signature Walter Ford (M. D. or other) _____
Address _____ Date signed _____

