

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

36344

State File No. \_\_\_\_\_

Registration District No. 784

Primary Registration District No. 107

Registrar's No. 1987

I. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town Ladue Village  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
26 Dramara Rd.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 20  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Catherine Cody

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

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

6. (b) Name of husband or wife John J. Cody 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Dec. 8, 1867  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
72 10 12 hr. \_\_\_\_\_ min.

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

10. Usual occupation At home

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Patrick Horan,

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

14. Maiden name Margaret O'Brien,

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

16. (a) Informant Mrs. Wm. H. Bies,

(b) Address 26 Dramara Rd.

17. (a) Burial (b) Date thereof 10/23/40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

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

(b) Address Clayton Rd. at Concordia Lane

19. (a) OCT 21 1940 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis  
(c) City or town Ladue Village  
(If outside city or town limits, write "RURAL")  
(d) Street No. 26 Dramara Rd.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 20  
year 1940 hour 4 minute 45 P. M.

21. I hereby certify that I attended the deceased from 5/10/40 19\_\_\_\_ to 10/20/40 19\_\_\_\_;

that I last saw her alive on October 20th 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Anaemia Perniciosa Duration 5 months

Due to myocardial infarct 2 years

Due to \_\_\_\_\_

Other conditions 93 dl  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy no

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 Aug. E. Wickman (M. D. or other)

Address 4660 Maryland Date signed 10/20/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....

Licensed Embalmer No. 1999

P. O. Address St. Louis

**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.**