

Registration District No. 317

Primary Registration District No. 3069

Registrar's No. 1222

1. PLACE OF DEATH:

(a) County St. Louis.
(b) City or town Richmond Heights
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Mary's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 17 years years, months or days)

3. (a) PRINT FULL NAME Eugene Coddington

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

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Lillie Louise 6. (c) Age of husband or wife if alive 83 years

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

8. AGE: Years Months Days If less than one day
88 9 21 hr. min.

9. Birthplace Woodbridge N.J.
(City, town, or county) (State or foreign country)

10. Usual occupation Commission Merchant

11. Industry or business Live Stock

MOTHER FATHER
12. Name Randolph Coddington
13. Birthplace N. Jersey
(City, town, or county) (State or foreign country)
14. Maiden name Caroline Martin
15. Birthplace New Jersey
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature E. S. St. Louis

(b) Address E. St. Louis 711

17. (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof May 22 1943
(Month) (Day) (Year)

(c) Place: burial or cremation St. John's Cemetery, Parkville

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

(b) Address East St. Louis 111

19. (a) 444 S. 1st St. (b) E. H. McRae, M.D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town Kirkwood
(If outside city or town limits, write "RURAL")
(d) Street No. 562 Woodlawn.
(If rural, give location)
(e) If foreign born, how long in U. S. A? 1 years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 22
year 1943 hour 6:00 minute A. M.

21. I hereby certify that I attended the deceased from Jan., 1939, to May 21, 1943;
that I last saw him alive on May 21, 1943;
and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerosis

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations none
Of autopsy none

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 Paul E. Rutledge (M. D. or other) MD
Address Kirkwood Mo Date signed 5-22-43

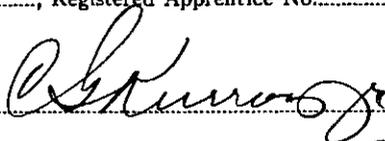
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WHILE FILLING IN—USE UNFADING INK—MAKE A PERMANENT RECORD

1951 8 1 11:53

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..... 3162

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, above space should be left blank.

1174
510 1174

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. June Cr
Registrar's No. 1222

Registration District No. 317

Primary Registration District No. 3069

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Fishers Heights
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Marys Hosp.
(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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Eugene Codrington

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

4. Sex M 5. Color W 6. (a) Single, widowed, married, divorced _____

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

7. Birth date of deceased: 7-31-1905
(Month) (Day) (Year)

8. AGE: Years 88 Months _____ Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 5-25-43 (b) E. J. McDaniel, M.D.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May Day 27 Year 1943 Hour _____ Minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____;
that I last saw him _____ 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)

(b) 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

MOTHER FATHER

SUPPLEMENTARY

S-18438