

FILED NOV 28 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 36523

BIRTH NO. _____		REG. DIST. NO. <u>128</u>		PRIMARY REG. DIST. NO. <u>2000</u>		Registrar's No. <u>1057</u>	
1. PLACE OF DEATH a. COUNTY <u>Greene</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>			
b. CITY (If outside corporate limits, write RURAL and give town(ship)) <u>Springfield</u>		c. LENGTH OF STAY (in this place) <u>42 days</u>		c. CITY OR TOWN <u>Springfield</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Springfield Baptist Hosp.</u>				• STREET ADDRESS (If rural, give location) <u>620 Tracy</u> <u>03710</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Ernest</u> b. (Middle) <u>—</u> c. (Last) <u>Coday</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 22-1955</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		8. DATE OF BIRTH <u>Oct. 20-1890</u>	
9. AGE (In years last birthday) <u>65</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done for most of working life, even if retired) <u>Pharmacist</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Pharmacy</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Wright County, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13a. FATHER'S NAME <u>James K.P. Coday</u>			13b. MOTHER'S MAIDEN NAME <u>Molly Coday</u>		14. NAME OF HUSBAND OR WIFE <u>Verba A. Coday</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>497-30-3219</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Robert Coday - R2-Rogersville, Mo.</u>			
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, athermia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Asphyxiation</u> ANTECEDENT CAUSES DUE TO (b) <u>Hemorrhage from nose</u> DUE TO (c) <u>Trauma to nose 9027</u> II. OTHER SIGNIFICANT CONDITIONS <u>Diabetes mellitus 45</u> <u>Leucemia, Lymphatic chronic</u>					INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>X</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Hospital</u>		21c. (CITY, TOWN, OR TOWNSHIP) <u>Springfield</u> (COUNTY) <u>Greene</u> (STATE) <u>Mo</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>Nov 22 55 10^{am}</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>It fell out of bed.</u>			
22. I hereby certify that I attended the deceased from <u>May</u> , 19 <u>47</u> , to <u>22 Nov</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>22 Nov</u> , 19 <u>55</u> , and that death occurred at <u>4:00 A.</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Stanley S. Peterson M.D.</u>				23b. ADDRESS <u>Springfield, Mo</u>		23c. DATE SIGNED <u>23 Nov 55</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>11-25-'55</u>		24c. NAME OF CEMETERY OR CREMATORY <u>White Chapel Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>Springfield, Missouri.</u>	
DATE REC'D BY LOCAL REG. <u>11-23-55</u>		REGISTRAR'S SIGNATURE <u>Edith Williamson</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Ray J. Jarmey Springfield, Mo.</u>			

(Licensed Embalmer's Statement on Reversed Side)

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

DEC 6 1955

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 _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. 33

P. O. Address Springh

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.