

R.I. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-025859

FILED VS JUL 29 1959

Registration District No. 87

Primary Registration District No. 3040

Registrar's No. 193

STATE FILE NUMBER

| | | | | | | | | |
|--|--|---|--|---|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Livingston</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Putnam</u> | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Chillicothe</u> | | Length of stay in 1b <u>9 Months</u> | | c. CITY OR TOWN <u>Powersville</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Susans Nursing Home</u> | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>D.</u> Last <u>Coddington</u> | | | | 4. DATE OF DEATH Month <u>July</u> Day <u>20</u> Year <u>1959</u> | | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>Sept. 6 1874</u> | 9. AGE (last birthday) <u>84</u> | IF UNDER 1 YEAR Months <u>10</u> Days <u>14</u> | IF UNDER 24 HR Hours <u></u> Min. <u></u> | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Owner</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u> | | 11. BIRTHPLACE (City and state or country) <u>Putnam Co. Missouri</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13a. FATHER'S NAME <u>David E. Coddington</u> | | | 13b. MOTHER'S MAIDEN NAME <u>Emma Roberts</u> | | 14. NAME OF HUSBAND OR WIFE <u>Stella Frances Coddington</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>none</u> | | 17. INFORMANT <u>Father E. Chapman, Beoria, Illinois</u> | | | Address <u>1407 R. Central Ave</u> |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> | | | | | | | <u>3 min.</u> | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) | | DUE TO (b) <u>Congestive left heart failure</u> | | | | | <u>2 years</u> | |
| | | DUE TO (c) <u>Mitral Stenosis</u> | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Generalized arteriosclerosis</u> | | | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> | SUICIDE <input type="checkbox"/> | HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | | | | |
| 20c. TIME OF INJURY Hour <u></u> a.m. <u></u> p.m. <u></u> | | Month, Day, Year <u></u> | | | | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> | | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 20f. CITY, TOWN, OR LOCATION | | COUNTY | | STATE |
| NOT WHILE AT WORK <input type="checkbox"/> | | | | | | | | |
| 21. I attended the deceased from <u>10-7-58</u> , to <u>7-20-59</u> and last saw ^{her} him alive on <u>6-24-59</u> Death occurred at <u>4:30 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE <u>James D. Mathey D.O.</u> | | | | 22b. ADDRESS <u>812 Clay St. Chillicothe Missouri</u> | | | 22c. DATE SIGNED <u>7/25/59</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>July 22 1959</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Powersville Cemetery</u> | | 23d. LOCATION (City, town, or county) (State) <u>Powersville Missouri</u> | | | |
| 24. FUNERAL DIRECTOR <u>W. W. Comstock</u> | | | | ADDRESS <u>Unionville, Mo</u> | | 25. DATE RECD. BY LOCAL REG. <u>7/25/59</u> | | 26. REGISTRAR'S SIGNATURE <u>Trance B Neill</u> |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUL 8 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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Elton F. Norman

Licensed Embalmer No. 4036
P. O. Address Chillicothe, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.