

FILED MAR 27 1944

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **2757**

1. PLACE OF DEATH:

(a) County St. Louis
 (b) City or town St. Louis
 (c) Name of hospital or institution 5429 Odell Ave 1
 (d) Length of stay: In hospital or institution _____
 In this community _____
 years, months or days

3. (a) PRINT FULL NAME Robert H. Caylor

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

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

6. (b) Name of husband or wife Lucinda Caylor 6. (c) Age of husband or wife if alive 75 years

7. Birth date of deceased May 5th 1850
 (Month) (Day) (Year)

8. AGE: Years 93 Months 10 Days 15 If less than one day _____ hr. _____ min.

9. Birthplace Cincinnati Ohio 1
 (City, town, or county) (State or foreign country)

10. Usual occupation Maintenance Man

11. Industry or business retired

MOTHER FATHER { 12. Name unknown Caylor 9
 13. Birthplace unknown
 (City, town, or county) (State or foreign country)
 14. Maiden name Martha unknown
 15. Birthplace Scotland PA
 (City, town, or county) (State or foreign country)

16. (a) Informant Lucinda Caylor

(b) Address 5429 Odell Ave.

17. (a) Burial (b) Date thereof 3-23-44
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Spew. St. Marcus Cemetery

18. (a) Signature of funeral director W. J. Bradeck

(b) Address 4228 So. Kingshighway

19. (a) MAR 22 1944 (b) W. J. Bradeck
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis
 (c) City or town St. Louis
 (d) Street No. 5429 Odell Ave
 (e) Citizen of foreign country? 0 (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 20th
 year 1944 hour 8 minute 4 M.

21. I hereby certify that I attended the deceased from 3-3
 to _____, 1944

that I last saw him alive on 3-20, 1944,
 and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Degeneration

Due to myocarditis

Due to _____

Other conditions _____

Major findings: _____
 Of operations _____
 Of autopsy _____

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? _____
 (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 W. J. Bradeck (M. D. or other) _____
 Address 3284 Franklin Date signed 3/22

Duration _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

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

Mr. Campbell

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 *Richard W. Steward*

Licensed Embalmer No *4007*

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.