

Filed Feb 2, 1949

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission.) a. STATE Mo b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place)	
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		d. STREET ADDRESS (If rural, give location) 2817a Cass Ave.	
d. FULL NAME OF HOSPITAL OR INSTITUTION City Hospital # 1			
3. NAME OF DECEASED (Type or Print) a. (First) William b. (Middle) E. c. (Last) Naylor		4. DATE OF DEATH (Month) (Day) (Year) 1 20 49	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 5-21-1882
9. AGE (In years last birthday) 66		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Garage Man.	11. BIRTHPLACE (State or foreign country) Bismark Mo.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Garage Man.		10b. KIND OF BUSINESS OR INDUSTRY Trucking Co	12. CITIZEN OF WHAT COUNTRY?
13a. FATHER'S NAME John Naylor		13b. MOTHER'S MAIDEN NAME Addie Caraway	14. NAME OF HUSBAND OR WIFE Mae Naylor
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Mae Naylor 2817a Cass Ave.
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Subdural Hematoma; Carcinoma of Lung; suppurated when second fell at City Hospital #1 Jan 18th 1949 exit ANTECEDENT CAUSES (b) Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) tear in vessel II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION Accident	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) City Shop	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St. Louis Mo. Mo.	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 1 18 49 m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 12:50 P.m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Catharine E. Taylor, Coroner		23b. ADDRESS	23c. DATE SIGNED 1-21-49
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 1-22-49	24c. NAME OF CEMETERY OR CREMATORY Bellefontaine Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis Mo.
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE J. B. Lasater	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Goodhart & Goodhart 2228 St. Louis Ave.		

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

over

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 _____

working under my personal supervision.

Student
Student Embalmer

Student Embalmer No. _____

Signed *Charles Goodhart*
Licensed Embalmer No. *2777*
P. O. Address *St Louis Mo*

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.