

FILED AUG 5 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 24667

318

1003

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. 6511	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE Missouri b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give town or town) St. Louis		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis		d. STREET ADDRESS (If rural, give location) 5400 Arsenal St.	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis State Hospital				d. STREET ADDRESS (If rural, give location) 5400 Arsenal St.			
3. NAME OF DECEASED (Type or Print) a. (First) ROBERT			b. (Middle) CALLICOTT			c. (Last) _____	
4. DATE OF DEATH (Month) (Day) (Year) July 24, 1949							
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH March 16, 1897	9. AGE (In years last birthday) 52	IF UNDER 1 YEAR Months _____	IF UNDER 1 YEAR Days _____	IF UNDER 1 YEAR Hours _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory Worker		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME Marshall Callicott			13b. MOTHER'S MAIDEN NAME Unknown			14. NAME OF HUSBAND OR WIFE None	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT'S SIGNATURE OR NAME James Ryan, 4919 Lisette 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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive Cardio Vascular Disease					INTERVAL BETWEEN ONSET AND DEATH 1943x
		ANTECEDENT CAUSES DUE TO (b) Uremia					
		DUE TO (c) _____					
		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 _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) 9300 (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? HSAI			
22. I hereby certify that I attended the deceased from June 1, 1949 , to July 24, 1949 , that I last saw the deceased alive on July 24, 1949 , and that death occurred at 6:10 p. m. , from the causes and on the date stated above.							
23a. SIGNATURE Dee... M... M.D. (Degree or title)				23b. ADDRESS 5400 Arsenal St.		23c. DATE SIGNED 7/25/49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 7-28-49		24c. NAME OF CEMETERY OR CREMATORY Memorial Park		24d. LOCATION (City, town, or county) (State) Normandy, Mo.	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE J. B. Foster				25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Morrell Funeral Home, 4212 St. Louis Ave.			

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

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 Me

Student Embalmer No. _____

working under my personal supervision.

Signed Edouard Revellius

Signed _____
Student Embalmer

Licensed Embalmer No. 4283

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.