

FILED DEC 22 1947 **318**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County **St. Louis**  
(b) City or town **St. Louis**  
(c) Name of hospital or institution **St. Ann's Hospital**  
(d) Length of stay: In hospital or institution

In this community, years, months or days

3. (a) PRINT FULL NAME **Robert E. Cadle**

3. (b) If veteran, name war **493-09-6371**

5. Color or race **White**  
6. (a) Single, widowed, married, divorced **Single**

6. (b) Name of husband or wife

7. Birth date of deceased **August 9 1899**  
(Month) (Day) (Year)

8. AGE: Years **48** Months **4** Days **3** If less than one day

9. Birthplace **Bedalia Mo**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Assistant Manager Chad Hotel**

11. Industry or business **Chad Hotel**

12. Name **Michael W. Cadle**

13. Birthplace **Ireland**  
(City, town, or county) (State or foreign country)

14. Maiden name **Mary McKeilly**

15. Birthplace **Ireland**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Rev. Robert McKeon**  
(b) Address **Farmington Mo.**

17. (a) Date of death **12-15-47**  
(b) Date of burial or cremation **12-15-47**  
(c) Place of burial or cremation **St. Ann's**

18. (a) Signature of funeral director **Stuart**  
(b) Address **1225 Union Blvd**

19. (a) Date received local registration **DEC 15 1947**  
(b) Registrar's signature **J. F. Bredek**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **St. Louis**  
(c) City or town **St. Louis**  
(d) Street No. **Chad Hotel 212 W. Kingshighway**  
(e) Citizen of foreign country? **No**  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH **Dec 12 1947** day **12** hour **12** minute **15** P.M.

21. I hereby certify that I attended the deceased from **NOV 15 1947** to **DEC 12 1947** that I last saw him alive on **DEC 12 1947** and that death occurred on the date and hour stated above.

Immediate cause of death **BRONCHOGENIC CARCINOMA**

Due to **HPC**

Due to

Other conditions **None**  
(Include pregnancy within 3 months of death)

Major findings: **CONFIRMED ABOVE**  
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? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

23. Signature **James L. Mull** (M. D. or other) **0**  
Address **634 N Grand** Date signed **12/13/47**

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

Sheet

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 Henry A. Brammer  
Licensed Embalmer No. 4200

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.