

SEP 28 1927

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

24225

1. PLACE OF DEATH

County Jackson
Township Blue
City Independence

Registration District No. 398
Primary Registration District No. 5034

File No. _____
Registered No. 224
St. _____ Ward) _____

2. FULL NAME

Frank D. Castle
(a) Residence. No. 1925 Cottage Englewood Ward. _____
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 14 mos. _____ da. _____ How long in U.S., if of foreign birth? yrs. _____ mos. _____ da. _____ (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Married

5K. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

Sarah Castle

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

March 12 - 1856

7. AGE

71517

If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Retired Baker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN, STATE OR COUNTRY)

Fairfield Michigan

10. NAME OF FATHER

D. C. Castle

11. BIRTHPLACE OF FATHER (CITY OR TOWN, STATE OR COUNTRY)

New York

12. MAIDEN NAME OF MOTHER

Phyllis Debas

13. BIRTHPLACE OF MOTHER (CITY OR TOWN, STATE OR COUNTRY)

Unknown

14.

INFORMANT (Address)

Sarah Castle 1925 Cottage Englewood

15.

FILED

Aug 30, 1927 Englewood

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug. 29 192717. I HEREBY CERTIFY, That I attended deceased from June 20 1927, to Aug 13 1927, that I last saw him alive on Aug 13 1927, and that death occurred, on the date stated above, at 11 AM m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Paralysis
7 1/2 yrs. _____ mos. _____ da.
8 1/2 yrs. _____ mos. _____ da.
CONTRIBUTORY Lead Poisoning
(SECONDARY) (duration) _____ yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? _____

DID AN OPERATION PRECEDE DEATH? no DATE OF Aug 29WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Shelton, M. D.(Address) Fairmount Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Mt. Washington Cem. 8-30 1927

20. UNDERTAKER

ADDRESS

C. D. Harrison for Indep. Mo.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

