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

Do not use this space.

7128

1. PLACE OF DEATH

County ..... Registration District No. 791 ..... File No. .....

Township ..... Primary Registration District No. 1003 ..... Registered No. 2000

City St Louis (No. 5351 Delmar Blvd St. ..... Ward)

2. FULL NAME Mary E. Castle

(a) Residence. No. 5351 Delmar Blvd St., 12 Ward. .....
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Female	White	Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED ~~HUSBAND OF~~ (OR) WIFE OF Daniel W. Castle

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 24, 1850

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
79	7	1	

8. OCCUPATION OF DEECEASED
(a) Trade, profession, or particular kind of work Lone
(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) Germany

PARENTS
10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Germany
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Germany

14. INFORMANT Edward F. Bush
(Address) 4031 Labadie Ave

15. FEB 25 19 ..... FILED ..... 19 ..... Mark E. Stanley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 25, 1930

17. I HEREBY CERTIFY, That I attended deceased from Aug 1, 1929, to Feb 25, 1930, that I last saw h. alive on Feb 24, 1930, and that death occurred, on the date stated above, at 12:20 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Myocarditis
45 yrs
10 mos
(duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Chronic Bronchitis
non Tuberculous (duration) ..... yrs. 6 mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED .....
IF NOT AT PLACE OF DEATH .....
DID AN OPERATION PRECEDE DEATH? No DATE OF —
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Phys Exam only
(Signed) Colon Carmichael M. D.
Feb 25, 1930 (Address) Metropolitan Bldg

*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. Lebanon Cemetery	Feb. 27, 1930
20. UNDERTAKER	**ADDRESS**
Drehmann Funeral	1905 Union

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.

Metropolitan B

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