

FILED SEP 18 1944

State File No.

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 7648

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St. Louis, Mo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: En Route City Hospital 2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution No (Specify whether)  
In this community 19 Years  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 610 Lafayette Ave.  
(If rural, give location)  
(e) Citizen of foreign country? Had first Papers (Yes or No)  
If yes, name country Mexico

3. (a) PRINT FULL NAME TELE CASTELLANOS

3. (b) If veteran, name war No 3. (c) Social Security No. NO

4. Sex F 5. Color or race Mex. 6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Arcadio 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Jan. 5th 1866  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
78 7 28 hr. \_\_\_\_\_ min.

9. Birthplace Mexico  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business At Home

12. Name Urijido Castellanos

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

14. Maiden name Unknown

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

16. (a) Informant Concha M. Ochoa

(b) Address 610 Lafayette Ave.

17. (a) Burial (b) Date thereof 9/5/44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation SS Peter & Paul Cem.

18. (a) Signature of funeral director A. V. McLaughlin

(b) Address 2301 Lafayette Ave.

19. (a) SEP 5, 1944 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 3rd  
year 1944 hour 10 minute 30 N. M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_,  
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Sclerosis  
Arterio Sclerosis

Due to [Signature]  
Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN

Underline the cause to which death should be charged statistically.

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury [Signature]

23. Signature [Signature] (M. D. or other)  
Address [Signature] Date signed 9-5-44

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

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**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.....

*L. R. Cooper*

Licensed Embalmer No. *3633*

P. O. Address *2317 W. Fayette*

**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.**