

FILED FEB 7 1946 STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 426

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Josephs Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day
(Specify whether
In this community 20 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")
(d) Street No. 5715 McGee Street 8
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Katherine B. Castle
KATHERINE B. CASTLE

3. (b) If veteran, name war No.
3. (c) Social Security No. None

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Widow 7

6. (b) Name of husband or wife Charles L. Castle
6. (c) Age of husband or wife if alive Dead years

7. Birth date of deceased June 25, 1866
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>79</u>	<u>7</u>	<u>0</u>	hr. min.

9. Birthplace Shackelford Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business Home

12. Name Thomas Barr

13. Birthplace Unknown Ireland 4
(City, town, or county) (State or foreign country)

14. Maiden name Mary Grant

15. Birthplace Unknown Ireland 4
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Emily Collins

(b) Address 5715 McGee St, K.C. Mo.

17. (a) Burial (b) Date thereof 1-28-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Shackelford, Mo.

18. (a) Signature of funeral director Melody-McGilley-Eylar

(b) Address 1800 Linwood Blvd. K.C. Mo.

19. (a) 1-26-46 (b) Theraldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 25
year 1946 hour _____ minute _____

21. I hereby certify that I attended the deceased from Several
years 19____ to date of death 1-25-46
that I last saw h_er alive on 1/24/46 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardia
arterio-sclerosis
Senility

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations 932

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) _____ (e) Means of injury _____

23. Signature John B. Bryan (M. D. or other) _____
Address 1402 Bryan Date signed 1-25-46

Duration _____
Underline the cause to which death should be charged statistically.

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

880

Handwritten notes:
12/10/11
C. J. Shaw
12/10/11

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.....

Licensed Embalmer No.

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.