

FILED JUL 22 1948

Registration District No. **318**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. L. City Hospital #1. Max C. Starkloff
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 22 hours
(Specify whether
In this community 4 years
years, months or days)

3. (a) PRINT FULL NAME MARVIN F. CHASTEEN

3. (b) If veteran, name war Spanish American 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife Dora 6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased February 1, 1875
(Month) (Day) (Year)

8. AGE: Years 73 Months 5 Days 9 If less than one day hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business Retired

MOTHER FATHER { 12. Name Nelson Chasteen
13. Birthplace Unknown
14. Maiden name Mary Jane Proffer
15. Birthplace Unknown

16. (a) Informant Dona Phillips
(b) Address 1919 Park Avenue

17. (a) Removal (b) Date thereof 7-11-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rector, Arkansas

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

(b) Address 2301 Lafayette Avenue

19. (a) JUL 11 1948 (Date received local registrar) J. F. Bredeek (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 1828a Park Avenue
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 10 year 1948 hour 5:15 minute P M.

21. I hereby certify that I attended the deceased from many years, 19____ to July 10, 1948
that I last saw him alive on July 10, 1948
and that death occurred on the date and hour stated above

Immediate cause of death Brain, Encephalomalacia Duration 24 hrs.

Due to Cerebral arteriosclerosis yrs

Due to 93

Other conditions arteriosclerotic yrs
Cardiovascular disease

Major findings: _____
Of operations _____
Of autopsy as above

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? 0

While at work? _____ (Specify type of place) (e) Manner of injury _____
3. Signature Geo. A. Seib (M. D. or other) MD
Address 2323 Lafayette Date signed 7-11-48

WRITE PLAINLY—USE UNFADING INK

79010 3-9-1174

[Handwritten scribble]

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 *C. H. Cooper*

Licensed Embalmer No. *3830*

P. O. Address *2301 Lafayette*

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.