

S. No. 2
M-2-43
5-17-39

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **27193**

FILED SEP 15 1948

Registration District No. **264**

Primary Registration District No. **6891**

Registrar's No. **21**

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

1. PLACE OF DEATH:

(a) County **Ozark**

(b) City or town **Bridges - rural**

(c) Name of hospital or institution: **Gainesville Mo 1**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **2 days** (Specify whether in this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Ozark**

(c) City or town **rural - Gainesville**
(If outside city or town limits, write "RURAL")

(d) Street No. **77**
(If rural, give location)

(e) Citizen of foreign country? **0** (Yes or No)
If yes, name country **0**

3. (a) PRINT FULL NAME **Ernest Nicholas Kastning**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **9** year **1948** hour _____ minute **45** P.M.

21. I hereby certify that I attended the deceased from **9-9-48** to **9-9-48** 19____; that I last saw **in** alive on **9-9-48** 19____; and that death occurred on the date and hour stated above.

4. Sex **male**

5. Color or race **white**

6. (a) Single, widowed, married, divorced **widowed**

6. (b) Name of husband or wife **Rosella Kastning**

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: **Year 9 1879**
(Month) (Day) (Year)

Immediate cause of death: **Cerebral hemorrhage** Duration **7-hr**

Due to **Arterial hypertension**

Due to _____

8. AGE: Years **69** Months **6** Days **0** If less than one day hr. _____ min. _____

9. Birthplace **Bell Mo**
(City, town or county) (State or foreign country)

10. Usual occupation **farmer**

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

Major findings: Of operations **9-9-48**

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

MOTHER FATHER

11. Industry or business _____

12. Name **John William Kastning**

13. Birthplace **unknown 911**
(City, town or county) (State or foreign country)

14. Maiden name **Mary Shanks**

15. Birthplace **unknown 9**
(City, town or county) (State or foreign country)

16. (a) Informant **Clarence Kastning**

(b) Address **Bruney, Mo**

17. (a) **burial** (b) Date thereof **9-11-48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Lily Ridge**

18. (a) Signature of funeral director **Alexander Keller**

(b) Address **Mo Home Lick**

19. (a) **9-10-48** (b) **William Keller**
(Date received local registrar) (Registrar's signature)

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 _____

23. Signature **M. J. Hoerman** (M.D. or other) **DO**

Address **Gainesville, Mo** Date signed **9/10/48**

RECEIVED

District Health Officer No. 6;

District File Number 948-1052

Date Filed SEP-13-1940

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 Denver Roller

Licensed Embalmer No. 4006

P. O. Address Intn. Home, Ark.

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.