

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **2539**
281

FILED JAN 19 1949

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1003

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____ Registrar's No. _____

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

1. PLACE OF DEATH a. COUNTY b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN c. LENGTH OF STAY (in this place) d. FULL NAME OF HOSPITAL OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE b. COUNTY c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN d. STREET ADDRESS (If rural, give location)	
a. COUNTY: _____ b. CITY: St Louis c. LENGTH OF STAY: _____ d. FULL NAME OF HOSPITAL OR INSTITUTION: Alexian Bros. Hospital		a. STATE: Missouri b. COUNTY: _____ c. CITY: St Louis d. STREET ADDRESS: 26 3525 No Broadway	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) Whipple J Castle		4. DATE OF DEATH (Month) (Day) (Year) 1-7-1949	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 12-1-1900
9. AGE (In years last birthday) 48	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 15 Hrs. Hours _____ Min. _____	11. BIRTHPLACE (State or foreign/country) Lincoln / NEBRASKA
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME John Castle		13b. MOTHER'S MAIDEN NAME Sadie Vineent	
14. NAME OF HUSBAND OR WIFE Lucille		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____	
16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Lucille Castle 3525 No Broadway	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinomatosis of Rt. lung and all of liver ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) Tertiary Venereal Disease	
19a. DATE OF OPERATION 1-6-49		19b. MAJOR FINDINGS OF OPERATION Marked Carcinomatosis of entire liver	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21. INTERVAL BETWEEN ONSET AND DEATH Approx 1 yr.	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____	21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. _____
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____	
22. I hereby certify that I attended the deceased from Dec. 1, 1948, to Jan 7, 1949, that I last saw the deceased alive on Jan 7, 1949, and that death occurred at 12-15 P.M., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) J. J. Czapciak M.D.		23b. ADDRESS 1901 Madison St.	23c. DATE SIGNED 1-9-49
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 1-8-1949	24c. NAME OF CEMETERY OR CREMATORY _____	24d. LOCATION (City, town, or county) (State) Lincoln, Nebraska
DATE REC'D BY LOCAL REG. JAN 11 1949		25. FUNERAL DIRECTOR Rowland Mortuary Service 4104 Manchester Ave.	
REGISTRAR'S SIGNATURE J. B. Pascher		25. FUNERAL DIRECTOR Rowland Mortuary Service	

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Embalmed by J. Allen Davis Jr #40
Othello 10, 19