

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31015

State File No.

FILED OCT 14 1949

BIRTH NO. _____		REG. DIST. NO. <u>201</u>		PRIMARY REG. DIST. NO. <u>4314</u>		Registrar's No. _____		
1. PLACE OF DEATH a. COUNTY <u>Macon</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Macon</u>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Atlanta</u>		c. LENGTH OF STAY (in this place) <u>1 year</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Atlanta</u>		61		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1</u>				d. STREET ADDRESS (If rural, give location) _____				
3. NAME OF DECEASED (Type or Print) a. (First) <u>Anna</u> b. (Middle) <u>Castee</u> c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) <u>Oct 2 1949</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>		8. DATE OF BIRTH <u>Oct 29 1868</u>		
9. AGE (In years last birthday) <u>80</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 2 HRS. Hours _____ Min. _____				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeping</u>			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Shaw's Point, Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Samuel Deffenbach</u>			13b. MOTHER'S MAIDEN NAME <u>Mary Walker</u>		14. NAME OF HUSBAND OR WIFE <u>R. C. Castee</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>A. W. Castee</u> ADDRESS <u>Atlanta Mo</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic Nephritis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertensive Cardio-</u> <u>vascular Disease</u> DUE TO (c) <u>Hypertension</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Arterio sclerosis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u> <u>about 2 yrs</u> <u>about 20 yrs</u> <u>unknown</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____						
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? <u>592X</u>				
22. I hereby certify that I attended the deceased from <u>April</u> , 1949, to <u>10-2</u> , 1949, that I last saw the deceased alive on <u>10-2</u> , 1949 and that death occurred at _____ m., from the causes and on the date stated above.								
23a. SIGNATURE <u>[Signature]</u> (Degree or title) _____				23b. ADDRESS <u>Macon Mo</u>		23c. DATE SIGNED <u>10-3-49</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>Oct 3, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Magnolia Cemetery Magnolia</u>		24d. LOCATION (City, town, or county) (State) <u>Ill. Ill.</u>		
DATE REC'D BY LOCAL REG. <u>Oct 4 - 49</u>		REGISTRAR'S SIGNATURE <u>Mrs O B Griffin</u> 186		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>Atlanta Mo</u>		

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

H. E. ...

RECEIVED 10/13/49
MACON Co. Health Dept
Co. File No. 1049/23
DATE FILED 10/13/49

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *A. M. Gooding* _____

Licensed Embalmer No. *1750* _____

P. O. Address *Atlanta, Mo.* _____

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.