

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **21685**  
**5130**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Illinois</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>Centralia</b> <b>8170</b>	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) <b>1007 E. Noleman</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>St. Anthony's Hospital</b>			

3. NAME OF DECEASED (Type or Print) <b>KENETH</b>	a. (First)	b. (Middle)	c. (Last) <b>KASTEN</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>June 9, 1950</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>Unknown</b>	9. AGE (In years last birthday) <b>Abt. 3</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Centralia, Ill. /</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Oscar Kasten</b>	13b. MOTHER'S MAIDEN NAME <b>Irene Holle</b>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME <b>Oscar Kasten - Centralia, Ill</b>	ADDRESS
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Comminuted fracture of skull.</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <b>Laceration of brain suffered when increased fall from truck in auto driven by Oscar Kasten</b> <b>Hardy # 141 near Linton, Mo</b> <b>about 8:45 pm June 9 1950</b>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>Accident</b>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT (Specify) <b>Accident</b>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Hardy</b>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>Mo</b>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>June 9 50 3:45 p.m.</b>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>E. 82 ft</b>
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22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at **3:45 P. m.**, from the causes and on the date stated above.

22a. SIGNATURE <b>Patrick E Taylor Cor 3</b>	(Degree or title)	23b. ADDRESS <b>1300 Clark</b>	23c. DATE SIGNED <b>6. 12. 50</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>6/12/50</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Hill Crest Mem. Park</b>	24d. LOCATION (City, town, or county) (State) <b>Centralia, Ill.</b>
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DATE REC'D BY LOCAL REG. <b>JUN 12 1950</b>	REGISTRAR'S SIGNATURE <b>J B Foster</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Queen Rose Funeral Home Centralia, Ill</b>	ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

*mm*

**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 \_\_\_\_\_

working under my personal supervision.

Student Embalmer No. ....

Signed Ronald O. Yank

Signed.....  
Student Embalmer

Licensed Embalmer No. 3517

P. O. Address W. L. L...

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.