

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

State File No. **20281**

FILED JUN 10 1953

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **500** Registrar's No. **1455**

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. HOSPITAL OR INSTITUTION 10442 Bellefontaine Rd.		d. STREET ADDRESS (If rural, give location) 4534 Red Bud Ave.	

3. NAME OF DECEASED (Type or Print) a. (First) MARIE b. (Middle) WILHELMINA c. (Last) CASTLE			4. DATE OF DEATH (Month) (Day) (Year) May 24 1953		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Sep. 16, 1883	9. AGE (In years last birthday) 69	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (City and State or Foreign Country) Charleston, So. Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown	
14. NAME OF HUSBAND OR WIFE Late George W. Castle		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	

17. INFORMANT'S SIGNATURE OR NAME Mrs. E.B. Tolson		ADDRESS 5417 Walsh St.	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH 3-4
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		ANTECEDENT CAUSES			
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (b) _____			
DUE TO (c) _____		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis			

19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION 331X		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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) _____		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 **4-22, 1953**, to **5-22, 1953**, that I last saw the deceased alive on **5-22, 1953**, and that death occurred at **10:15P m.**, from the causes and on the date stated above.

23a. SIGNATURE [Signature] (Degree or title) _____		23b. ADDRESS 8201 N Broadway		23c. DATE SIGNED 5/25/53	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal (Rail)		24b. DATE 5-28-53		24c. NAME OF CEMETERY OR CREMATORY _____		24d. LOCATION (City, town, or county) (State) Salem, Ill.	
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DATE REC'D BY LOCAL REG. 5-26-53		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE [Signature]		ADDRESS Kriegshauser 4228 S. Kingshighway Bl	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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

William R. White

Licensed Embalmer No. *4291*

P. O. Address *2228 Kings Highway*

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.