

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

29847

State File No. ....

FILED AUG 31 1953

1003

Registrar's No. .... 7604

BIRTH NO. ....		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. NO. ....		Registrar's No. .... 7604			
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE				b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (In this place)		c. CITY OR TOWN <u>St. Louis</u>		d. Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION. <u>St. Louis State Hospital</u>				e. STREET ADDRESS (If rural, give location) <u>13</u> <u>5400 Arsenal St.</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>JOSEPHINE</u>			b. (Middle)			c. (Last) <u>CASTELLANO</u>			
4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 2, 1953.</u>			5. SEX <u>Female</u>			6. COLOR OR RACE <u>White</u>			
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>			8. DATE OF BIRTH <u>Feb. 26 1898</u>			9. AGE (In years last birthday) <u>55</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (City and State or Foreign Country) <u>Louisiana</u>			
12. CITIZEN OF WHAT COUNTRY?			13a. FATHER'S NAME <u>Thomas Gleason</u>			13b. MOTHER'S MAIDEN NAME <u>Mary Hellier</u>			
14. NAME OF HUSBAND OR WIFE <u>Castellano</u>			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 <u>F.A. Casserly</u>			17. ADDRESS <u>#8 Chilton Rt2 CouerMo</u>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute diffuse tuberculous pneumonia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1953</u>			II. OTHER SIGNIFICANT CONDITIONS			
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.			ANTECEDENT CAUSES			DUE TO (b) <u>Pulmonary tuberculosis-far advanced</u> 1952			
DUE TO (c) <u>Acute Lukemia</u>			1953			19. DATE OF OPERATION			
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) <u>002X</u>			21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)			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 <u>Jan. 1, 1953</u> , to <u>Aug. 2, 1953</u> , that I last saw the deceased alive on <u>Aug. 2, 1953</u> , and that death occurred at <u>6:45p</u> m., from the causes and on the date stated above.			23a. SIGNATURE (Degree or title) <u>John H. Weeber M.D.</u>			
23b. ADDRESS <u>5400 Arsenal St.</u>			23c. DATE SIGNED <u>8/3/53</u>			24. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			
24b. DATE <u>Aug 5- 53</u>			24c. NAME OF CEMETERY OR CREMATORY <u>Calvary</u>			24d. LOCATION (City, town, or county) (State) <u>St. Louis Mo</u>			
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>AUG 4 1953</u> <u>J. Carl Smith M.D.</u>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>E.J. Schnur 3125 Lafayette</u>						

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

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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.....  
Signature of Student Embalmer

Signed..... *Joe B. Vollmer*

Licensed Embalmer No. *410*

P. O. Address *3125 Lafayette*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.