

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

**35613**

State File No. ....

No. 300  
10.48

**FILED NOV 9 - 1953**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2002 Registrar's No. 991

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Greene</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Christian</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>Springfield</b>	c. LENGTH OF STAY (in this place) <b>9 days</b>	c. CITY OR TOWN <b>"Rural" Polk</b>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Baptist Hospital</b>		e. STREET ADDRESS (If rural, give location) <b>Route #2, Billings</b>	

<b>3. NAME OF DECEASED</b> (Type or Print) <b>KARL DIETRICK KASTENDIECK</b>			<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>Nov. 1, 1953</b>		
a. (First)		b. (Middle)		c. (Last)	

<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> (Specify) <b>Married</b>	<b>8. DATE OF BIRTH</b> <b>Oct. 5-1897</b>	<b>9. AGE</b> (In years last birthday) <b>56</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>27</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
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<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Farmer &amp; Dairyman</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>General Farming</b>		<b>11. BIRTHPLACE</b> (City and State or Foreign Country) <b>Billings, Missouri</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
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<b>13a. FATHER'S NAME</b> <b>John D. Kastendieck</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>Louise Franck</b>		<b>14. NAME OF HUSBAND OR WIFE</b> <b>Minnie Feiter, Kastendieck</b>			
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<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT'S SIGNATURE OR NAME</b> ADDRESS <b>Mrs. Karl Kastendieck, Billings, Mo.</b>			
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<b>18. CAUSE OF DEATH</b> Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		<b>MEDICAL CERTIFICATION</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>2 1/2 yrs.</b>	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		<b>Chronic Nephritis</b>				II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death <b>Arteriosclerosis - Hypertension</b>	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b)		<b>Nephrosclerosis - Hypertension</b>		III. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death <b>Arteriosclerosis - Hypertension</b>	
		DUE TO (c)		<b>Arteriosclerosis - Hypertension</b>		<b>5 yrs</b>	

<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b> <b>446x</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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<b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify)		<b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)</b>		
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) m.		<b>21e. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>		

**22. I hereby certify that I attended the deceased from** Nov 1, 1950, to Nov 1, 1953 that I last saw the deceased alive on Nov 1, 1953, and that death occurred at 445a. m., from the causes and on the date stated above.

<b>23a. SIGNATURE</b> (Degree or title) <b>Ray C. Callaway MD</b>		<b>23b. ADDRESS</b> <b>Springfield Mo</b>		<b>23c. DATE SIGNED</b> <b>11/2/53</b>	
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<b>24a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>	<b>24b. DATE</b> <b>11-3-1953</b>	<b>24c. NAME OF CEMETERY OR CREMATORY</b> <b>St. Peter's Evangelical</b>	<b>24d. LOCATION</b> (City, town, or county) (State) <b>Billings, Missouri</b>		
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<b>DATE REC'D BY LOCAL REG.</b> <b>11-3-53</b>	<b>REGISTRAR'S SIGNATURE</b> <b>John Williams</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>John Dean Harris</b>		<b>ADDRESS</b> <b>Clever, Mo</b>
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(Licensed Embalmer's Statement on Reverse Side)

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

STANDARD CERTIFICATE OF DEATH

COUNTY OF _____ STATE OF _____ CITY OF _____ TOWN OF _____ STREET _____ HOUSE NO. _____ DEATH NO. _____	DEATH OF _____ (Name of Deceased) (Sex and Age) (Cause of Death) (Date and Time) (Place) (Signature of Physician) (Signature of Coroner) (Signature of Registrar)
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JAN 2 1900

**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 John Alan Harris

Licensed Embalmer No. 4390

P. O. Address Cleveland, Ohio

**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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
 If this body is not embalmed, fact should be so stated above.