

FILED JAN 17 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

200

BIRTH NO. ....		REG. DIST. NO. 42		PRIMARY REG. DIST. NO. 1000		Registrar's No. 27	
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).			
a. COUNTY Buchanan, 0117 N		a. STATE Missouri		b. COUNTY Andrew			
b. CITY (If outside corporate limits, write RURAL and give town) St. Joseph		c. LENGTH OF STAY (in this place) 1044.44.21.4p		c. CITY OR TOWN Anagnonia		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 State Hospital No. 2.				STREET ADDRESS (If rural, give location) R.R. # 2, 0020			
3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH				
a. (First) EVERETT		b. (Middle) - F -		c. (Last) CASTLE,		4. DATE OF DEATH (Month) (Day) (Year) JAN. 7-1955	
5. SEX Male		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single		8. DATE OF BIRTH 8-30-1916	
9. AGE (In years last birthday) 38		IF UNDER 1 YEAR Months 4		IF UNDER 1 HRS. Days 7			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Agriculture		11. BIRTHPLACE (City and State or Foreign Country) Anagnonia, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME A.S. Castle			13b. MOTHER'S MAIDEN NAME Hannah Walter			14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no.		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS J.S. Castle, St. Joseph, Mo., R.R. # 2,			
18. CAUSE OF DEATH		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
Enter only one cause per line for (a), (b), and (c)		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic myocarditis				yrs.	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES					
		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.					
		DUE TO (b)					
		DUE TO (c) Epilepsy with focalusio,					
		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 3533				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) (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 2-20-1942, to 1-7-1955, that I last saw the deceased alive on 1-7-1955, and that death occurred at 2:30 p. m., from the causes and on the date stated above.							
23a. SIGNATURE Forrest Thomas.			23b. ADDRESS (Degree or title) 0 9th D, State Hospital No. 2, St. Joseph, Mo.			23c. DATE SIGNED 1-7-1955	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Jan. 10, 1955		24c. NAME OF CEMETERY OR CREMATORY Green Cemetery		24d. LOCATION (City, town, or county) (State) St. Joseph, Missouri	
DATE REC'D BY LOCAL REG. Jan 14, 1955		REGISTRAR'S SIGNATURE (Signature) M. Allison		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS (Signature) Stanley Lawrence Home St. Joseph, Mo.			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADEING 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.. *Charles E. Bennett* .....

Licensed Embalmer No. *1167*

P. O. Address *St. Joseph*

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.