

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-010792
STATE OF MISSOURI
2-3169

FILED APR 10 1959

Registration District No. _____ Primary Registration District No. _____ Registration No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Lutheran Hospital		Length of stay in 1b 54 yrs	d. STREET ADDRESS (If outside, give location) 1809 Longfellow Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First JOSIAH Middle HAMILTON Last CASTLEMAN			4. DATE OF DEATH Month March Day 28 , Year 1959		
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5. SEX male <input type="checkbox"/> female <input checked="" type="checkbox"/>	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Setp. 10, 1873	9. AGE (In years last birthday) 85	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) retired High school teacher	10b. KIND OF BUSINESS OR INDUSTRY public schools	11. BIRTHPLACE (City and state or country) Woodville, Indiana	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Josiah Castleman	13b. MOTHER'S MAIDEN NAME Charlotte Elizabeth Ordway	14. NAME OF HUSBAND OR WIFE Leona Miller
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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) no	16. SOCIAL SECURITY NO. 496-28-0189	17. INFORMANT Mrs. Leona Castleman, 1809 Longfellow
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis INTERVAL BETWEEN ONSET AND DEATH 1 1/2 weeks	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) acute myocardial infarction one month
	DUE TO (c) Generalized Arteriosclerosis 5 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 420.1	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2	

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 420.1	
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m.		

20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____
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21. I attended the deceased from **10/1/58** to **3/28/59** and last saw her/him alive on **3/28/59**
Death occurred at **10:25 P.** on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Frieda Merten, M.D.	22b. ADDRESS 3701 Grandel Square	22c. DATE SIGNED 3/30/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE Apr. 3, 1959	23c. NAME OF CEMETERY OR CREMATORY Chesterton, Indiana	23d. LOCATION (City, town, or county) (State)
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24. FUNERAL DIRECTOR BEIDERWIEDEN F.H. INC., 1936 St. Louis Ave	25. DATE RECD. BY LOCAL REG. MAR 30 59	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.
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Health, Welfare, Public Service

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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

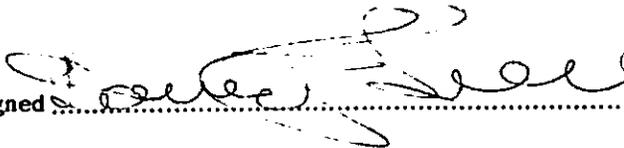
All diseases in Part I must be causally related.

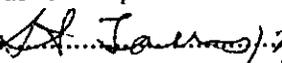
Dr. Frede Mortensen,
3701 Grandel Sq.
12:30 to 4 PM

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 

Licensed Embalmer No. 4520
P. O. Address 

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.