

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-020292
STATE FILE NUMBER

FILED JUN 26 1959 Registration District No. 002 Primary Registration District No. 4009 Registrar's No. 36

1. PLACE OF DEATH a. COUNTY ANDREW			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY ANDREW		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SAVANNAH		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN SAVANNAH		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION LaVerna Heights		Length of stay in lb 7 days	d. STREET ADDRESS 707 Price Ave.		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First SADIE Middle KASTENDIEK Last KASTENDIEK			4. DATE OF DEATH Month June Day 17 Year 1959		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-6-86	9. AGE (In years last birthday) 73	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired nurse		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Sauk County, Wisconsin		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME James T. Bryan		13b. MOTHER'S MAIDEN NAME Eliza Maria Dunlevy		14. NAME OF HUSBAND OR WIFE William Kastendiek	
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. 488-14-3351	17. INFORMANT Address Miss Hazel Reaugh, Savannah, Mo.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocarditis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) and arteries sclerosis. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4221					INTERVAL BETWEEN ONSET AND DEATH 10 yrs
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.)			
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT WORK <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
21. I attended the deceased from 6-27-47 to 6-17-59 and last saw her alive on 6-11-59 Death occurred at 7:20 PM on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE Corneil Long MD (Degree or title)			22b. ADDRESS Savannah Mo		22c. DATE SIGNED 6-19-59
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 6/20/59	23c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery		23d. LOCATION (City, town, or county) (State) Amazonia, Missouri
24. FUNERAL DIRECTOR ADDRESS Breit Funeral Home, Savannah			25. DATE RECD. BY LOCAL REG. 6-20-59	26. REGISTRAR'S SIGNATURE William Sparks	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

securing the medical certification in the specific manner required by 193.140 MoRS 1949.

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

V. S. 300
Rev. 1-57

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SEP 3 1959

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 *James B. Hawkins*
Licensed Embalmer No. *4536*
P. O. Address *Savannah*

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.