

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-022954

STATE FILE NUMBER
2 6126

REGISTRATION DISTRICT NO. _____ PRIMARY REGISTRATION DISTRICT NO. _____ REGISTRAR'S _____

1. PLACE OF DEATH
a. COUNTY _____
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis Inside Limits Yes No
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION 3526 Arsenal St. Length of stay in lb 10 yrs.
d. STREET ADDRESS (If outside, give location) 3526 Arsenal Street Reside on Farm Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY _____

3. NAME OF DECEASED (Type or print) First Middle Last
~~WILLIAM~~ WILLIAM OWEN HARDCASTLE

4. DATE OF DEATH Month Day Year
June 26, 1959

5. SEX Male 6. COLOR OR RACE White 7. MARRIED NEVER MARRIED WIDOWED DIVORCED 8. DATE OF BIRTH May 1, 1908 9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. 51 yrs.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk 10b. KIND OF BUSINESS OR INDUSTRY Amer. Red. Cross 11. BIRTHPLACE (City and state or country) Missouri 12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Jacob Hardcastle 13b. MOTHER'S MAIDEN NAME Nora Estes 14. NAME OF HUSBAND OR WIFE Mrs. Irma Miller Hardcastle

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. 489-12-1306 17. INFORMANT Mrs. Irma Hardcastle, 3526 Arsenal Street Address _____

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. IMMEDIATE CAUSE (a) Myocardial infarction INTERVAL BETWEEN ONSET AND DEATH 2 hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerotic heart disease 6 years plus
DUE TO (c) 4200

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES NO 2

20a. ACCIDENT SUICIDE HOMICIDE 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 NOT WHILE AT WORK 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 May 28, 1958 to June 26, 1959 and last saw ~~him~~ him alive on November 28, 1958
Death occurred at 9:10 P. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Benjamin H. Charles M.D. 22b. ADDRESS 3720 Washington Blvd., St. Louis 22c. DATE SIGNED 6/29/59

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal 23b. DATE June 29, 1959 23c. NAME OF CEMETERY OR CREMATORY Mount Hope Cemetery 23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri

24. FUNERAL DIRECTOR Beiderwieden F.H.Inc., 1936 St. Louis ADDRESS _____ 25. DATE RECD. BY LOCAL REG. JUN 29 1959 26. REGISTRAR'S SIGNATURE Roald Smith, M.D.

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

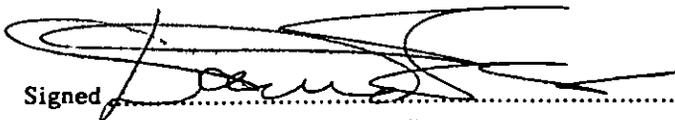
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STATEMENT BY LICENSED EMBALMER

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 

Licensed Embalmer No. 25
P. O. Address Albany

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.