. Health, & Welfare . Public h Service

S. 300 . 1-57

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-031727

STATE FILE NUMBER

Registration District No. 5-8 Primary Registration District No. 4-088 Registrar's No. 23

1. PLACE OF DEATH
a. COUNTY: CARTER
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ELLSINORE — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: RESIDENCE — Length of stay in 1b: 9 Months

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: CARTER
c. CITY OR TOWN: ELLSINORE — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): ELLSINORE — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: ORAN Middle: KNOX Last: CASTEEL

4. DATE OF DEATH: Month: Sept Day: 17 Year: 1959

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED [ ] **NEVER MARRIED** [ ] **WIDOWED** [X] **DIVORCED** [ ]

8. DATE OF BIRTH: APRIL 11, 1877

9. AGE (In years last birthday): 82 — IF UNDER 1 YEAR: Months: 5 Days: 6 — IF UNDER 24 HRS: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER

10b. KIND OF BUSINESS OR INDUSTRY: ARK. Hyway Dept

11. BIRTHPLACE (City and state or country): SALEM, MO

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: A.M. CASTEEL

13b. MOTHER'S MAIDEN NAME: JULIA BUTTS

14. NAME OF HUSBAND OR WIFE: DECEASED

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: ORA Casteel Address: ELLSINORE MO.

MEDICAL CERTIFICATION

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 5 Min
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 4201

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

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 a.m. p.m. Month, Day, Year

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 Dec 2 to Sept 17 and last saw her/him alive on
Death occurred at 6:40 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Coleman McSpadden Coroner 3

22b. ADDRESS: Van Buren, Mo.

22c. DATE SIGNED: 9/17/59

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE: Sept 19, 1959

23c. NAME OF CEMETERY OR CREMATORY: Smith Chapel

23d. LOCATION (City, town, or county) (State): ELLSINORE, MO

24. FUNERAL DIRECTOR: McSpadden ADDRESS: VAN BUREN, MO

25. DATE RECD. BY LOCAL REG.: Sept. 23-59

26. REGISTRAR'S SIGNATURE: Mrs Octa Henson

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.

CARTER COUNTY
HEALTH CENTER

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 Allen C. McBurney

Licensed Embalmer No. 4543

P. O. Address Van Buren, M

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.