

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-042836

FILED MO DEC 3 1959

Registration District No. 317 Primary Registration District No. 546 STATE FILE NUMBER 3004 Registrar's No. 3004

1. PLACE OF DEATH a. COUNTY <u>St. Louis County</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>ST LOUIS</u>	
b. CITY OR TOWN <u>Overland</u> (If outside corporate limits, give TOWNSHIP only) Inside Limits: Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Overland 409th</u> Inside Limits: Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>9704 Miriam</u> Length of stay in <u>1</u> b.		d. STREET ADDRESS <u>4507 Carson Road</u> (If outside, give location) Reside on Farm: Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Eura</u> Middle <u>b.</u> Last <u>Castleberry</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>11</u> Year <u>1959</u>			
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5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 30, 1900</u>	9. AGE (In years last birthday) <u>59</u>	10. UNDER 1 YEAR	11. IF UNDER 24 HRS
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>grocery business</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or country) <u>Sulphur Rock Ark.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Charles Louis Castleberry</u>	13b. MOTHER'S MAIDEN NAME <u>Emma Long</u>	14. NAME OF HUSBAND OR WIFE <u>Romayne Castleberry</u>
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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) <u>no</u>	16. SOCIAL SECURITY NO. <u>492-01-3477</u>	17. INDIAN? <u>no</u> Address <u>Res. 6. Turnbough 2708 W. Lindbergh St.</u>
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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) <u>ESTHESIO NEUROPATHY -</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 YRS</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>NASO PHARYNX</u>	
	DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>146x</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

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
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21. I attended the deceased from MARCH 1959 to PRESENT and last saw her alive on 1-4-59
Death occurred at 7 m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Margaret A Bender, M.D.</u>	22b. ADDRESS <u>4652 MARYLAND ST LOUIS MO</u>	22c. DATE SIGNED <u>11-12-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>Nov. 14, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lawrence Hill Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis County Mo.</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Bull. Campbell - 5165 Delmar</u>	25. DATE RECD. BY LOCAL REG. <u>11-12-59</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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.

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 *Stanley H. Dixon*

Licensed Embalmer No. *4193*

P. O. Address *St. Louis*

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.