

FILED VS APR 8 1960

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

60-010214

Registration District No. 5.8

Primary Registration District No. 40.88

STATE FILE NUMBER 9

S. 300
1-57

80

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY CARTER		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY CARTER	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ELLSINORE		c. CITY OR TOWN ELLSINORE	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION RESIDENCE		d. STREET ADDRESS (If outside, give location) ELLSINORE	
3. NAME OF DECEASED (Type or print) First ORA Middle CASTEEL Last CASTEEL		4. DATE OF DEATH Month MAR Day 14 Year 1960	
5. SEX 1 FEMALE	6. COLOR OR RACE WHITE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	8. DATE OF BIRTH 8-8-1899
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 60 Months 7 Days 6
11. BIRTHPLACE (City and state or country) ELLSINORE MO		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME ORAN K. CASTEEL		13b. MOTHER'S MAIDEN NAME ALICE BLUE	
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. NO	
17. INFORMANT BUCEL CASTEEL		Address 3377 LORRAINE E. ST. LOUIS 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) Multiple Metastases Carcinoma Cervix Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 171X DUE TO (c) 171X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 6 mo
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 ☐ NOT WHILE WORK ☐ 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 Aug 1959 to 6 months and last saw her alive on 10 months Death occurred at 9:00 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Dr. J. H. Harrison MD		22b. ADDRESS 321 Oak St. St. Louis MO	
22c. DATE SIGNED 4-2-60			
23a. BURIAL, CREMATION, OR OTHER (Specify) BURIAL	23b. DATE 3-16-1960	23c. NAME OF CEMETERY OR CREMATORY Mt. CARMEL	23d. LOCATION (City, town, or county) (State) CARTER Co. MO
24. FUNERAL DIRECTOR McSpadden		25. DATE RECD. BY LOCAL REG. April 5, 60	
26. REGISTRAR'S SIGNATURE Mrs Oeta Harrison			

MEDICAL CERTIFICATION

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 Donald B. Sloan....., Student Embalmer No. 606..... working under my personal supervision.

Student Donald B. Sloan.....
Signature of Student Embalmer

Signed Allen C. McGee.....

Licensed Embalmer No.

P. O. Address VAN BUREN, I.....

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.