

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-016686

FILED VS MAY 2 1960

Registration District No. Primary Registration District No. Registrar No. 4361

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS		Length of stay in 1b 114 DAYS	c. CITY OR TOWN ST. LOUIS Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VETS. ADMIN. HOSPT.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2407 O'FALLON, APT. 311 Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last T. C. CASTON			4. DATE OF DEATH Month Day Year APRIL 20, 1960			
5. SEX MALE	6. COLOR OR RACE NEGRO	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4/23/26	9. AGE (last birthday) 33	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR 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 ---	11. BIRTHPLACE (City and state or country) COAHOMA, MISS.	12. CITIZEN OF WHAT COUNTRY U.S.A.		

13a. FATHER'S NAME LEE CASTON		13b. MOTHER'S MAIDEN NAME ROSIE GRIFFIN		14. NAME OF HUSBAND OR WIFE TILLIE CASTON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW II		16. SOCIAL SECURITY NO. 498-20-5897		17. INFORMANT TILLIE CASTON Address 1229 N. 18TH ST., APT. 128 ST. LOUIS, MO.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) CARDIOVASCULAR COLLAPSE			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) CARCINOMATOSIS DUE TO (c) OAT CELL CARCINOMA OF LUNG 16 3x			

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 a.m. p.m. Month, Day, Year	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. Attended the deceased from 12/28/59 to 4/20/60 and last saw him alive on 4/20/60
Death occurred at 9:30 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>James M. Smith</i> (Degree or title) MD	22b. ADDRESS VAH, ST. LOUIS, MO.	22c. DATE SIGNED 4/21/60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATES M. G. L. C. NAME OF CEMETERY OR CREMATORY 4/25/60 National Cemetery	23d. LOCATION (City, town, or county) (State) Jefferson Barracks, Mo.
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24. FUNERAL DIRECTOR Charles J. Gates 4107 Finney	25. DATE RECD. BY LOCAL REG. APR 22 1960	26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>
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DOCUMENT

MEDICAL CERTIFICATION

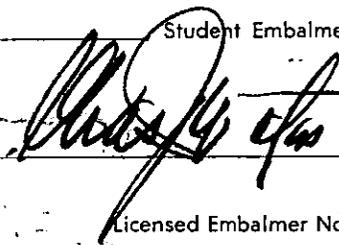
BY AFFIDAVIT OF

MAY 5 1960

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____ Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed  _____
Licensed Embalmer No. 1825
~~450~~

P. O. Address 4107 Finney

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.