JRI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS AUG 15 1960

60-029449
STATE FILE NUMBER

NDED

Registration District No. 373 Primary Registration District No. K545 Registrar's No. 33

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

1. PLACE OF DEATH
a. COUNTY: WEBSTER
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: MARSHFIELD MO
Length of stay in 1b: 25 YRS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION:
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MO
b. COUNTY: WEBSTER
c. CITY OR TOWN: MARSHFIELD
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location):
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: IRA Middle: CHARLES Last: CASTEEL
4. DATE OF DEATH: Month: Aug Day: 11 Year: 1960
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 2-23-1881
9. AGE (last birthday): 79
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): RET FARMER
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (City and state or country): MISSOURI
12. CITIZEN OF WHAT COUNTRY: U.S.A
13a. FATHER'S NAME: CHARLES CASTEEL
13b. MOTHER'S MAIDEN NAME: MARY EVANS
14. NAME OF HUSBAND OR WIFE:
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: RAY MEYERS Address: MARSHFIELD

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Anemia & Thrombosis Infarction. — INTERVAL BETWEEN ONSET AND DEATH: 2 years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerosis, Generalized. — 10yrs.
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Senile Dementia
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

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 1930, to Aug. 11, 1960 and last saw ~~him~~ him alive on Aug. 4, 1960
Death occurred at 11:45 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: C. P. Macdonnell, M.D. (Degree or title)
22b. ADDRESS: Marshfield, Mo.
22c. DATE SIGNED: 8/12/60

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: 8-13-1960
23c. NAME OF CEMETERY OR CREMATORY: GOOD HOPE
23d. LOCATION (City, town, or county) (State): WEBSTER Co MO

24. FUNERAL DIRECTOR: BARBER-EDWARDS ADDRESS: MARSHFIELD
25. DATE RECD. BY LOCAL REG.: 8-12-60
26. REGISTRAR'S SIGNATURE: J. Francis

(Licensed Embalmer's Statement on Reverse Side)

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_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No. 38

P. O. Address Mtn Grove

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