

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-008892

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2781

FILED MAR 14 1963

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>St Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before a. STATE <u>Illinois</u> b. COUNTY <u>East St Louis</u> (Mission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>St Louis Missouri</u>		Length of stay in 1b <u>37 Days</u>	c. CITY OR TOWN <u>East St Louis Illinois</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Washington-Glenon Hospital For Children</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>174 Amelia East St Louis Ill</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Bart</u> Middle <u>Douglas</u> Last <u>Kastler</u>			4. DATE OF DEATH Month <u>March</u> Day <u>9</u> Year <u>1963</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12-10-62</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	9. AGE (last birthday) <u>31 Months</u>
11a. BIRTHPLACE (City and state or country) <u>Illinois</u>		11b. BIRTHPLACE (City and state or country) <u>Illinois</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13. FATHER'S NAME <u>Neil B. Kastler</u>	
13b. MOTHER'S MAIDEN NAME <u>Joyce F (Schneckloth)</u>		14. NAME OF HUSBAND OR WIFE <u>-</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Neil A. Kastler</u> Address <u>E. St. Louis, Ill</u>
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>Myelomeningocele Pneumonitis</u> DUE TO (b) _____ DUE TO (c) <u>492x</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Myelomeningocele & cerebral/intestinal anomalies</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 Days</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 _____ a.m. _____ p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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. I attended the deceased from <u>1-3-63</u> to <u>3-8-63</u> and last saw ^{deceased} him alive on <u>3-8-63</u> Death occurred <u>12:30 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Dr. A. Palazzo</u>		22b. ADDRESS <u>4161 Lindell Blvd.</u>	22c. DATE SIGNED <u>3-9-63</u>
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>3-9-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CLARENCE Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>CLARENCE IOWA</u>
24. FUNERAL DIRECTOR <u>Schroeppeh</u> ADDRESS <u>Collinsville, Ill</u>		25. DATE RECD. BY LOCAL REG. <u>MAR 11 1963</u>	26. REGISTRAR'S SIGNATURE <u>Paul Smith, M.D.</u>

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 Frank Prokop

Licensed Embalmer No. 4356

P. O. Address St Louis Mo

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.