

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

7539

1. PLACE OF DEATH

County..... *Phelps*
Township.....
City..... *Rolla* (No. _____ Ward)

Registration District No. *677*
Primary Registration District No. *4403*

File No.
Registered No. *22*

2. FULL NAME

(a) Residence. No. _____ St. _____ Ward. _____
(Usual place of abode) (If nonresident give city or town and State)

Gladys Eugenia Castleman

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. - mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Married*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF *Herman Castleman*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *May 30 1904*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<i>21</i>	<i>10</i>	<i>14</i>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) *Stenographer*
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *Rolla*
(STATE OR COUNTRY) *Mo.*

10. NAME OF FATHER *Frank Merrill*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Rolla*
(STATE OR COUNTRY) *Mo.*

12. MAIDEN NAME OF MOTHER *Amanda Skyles*
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Rolla*
(STATE OR COUNTRY) *Mo.*

14. INFORMANT *Frank Merrill*
(Address) *Rolla Mo*

15. FILED *Feb. 14 1929* *Joe F. Ayers* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Feb 13 1929*

17. I HEREBY CERTIFY, That I attended deceased from *Feb 6*, 1929, to *Feb 13*, 1929, that I last saw her alive on *Feb 13*, 1929, and that death occurred, on the date stated above, at *9:25 a.m.*

THE CAUSE OF DEATH WAS AS FOLLOWS:
Lobar Pneumonia

108 (duration) yrs. mos. *7* da.

CONTRIBUTORY (SECONDARY) *101W* (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

0 DID AN OPERATION PRECEDE DEATH? *no* DATE OF.....

WAS THERE AN AUTOPSY? *no*

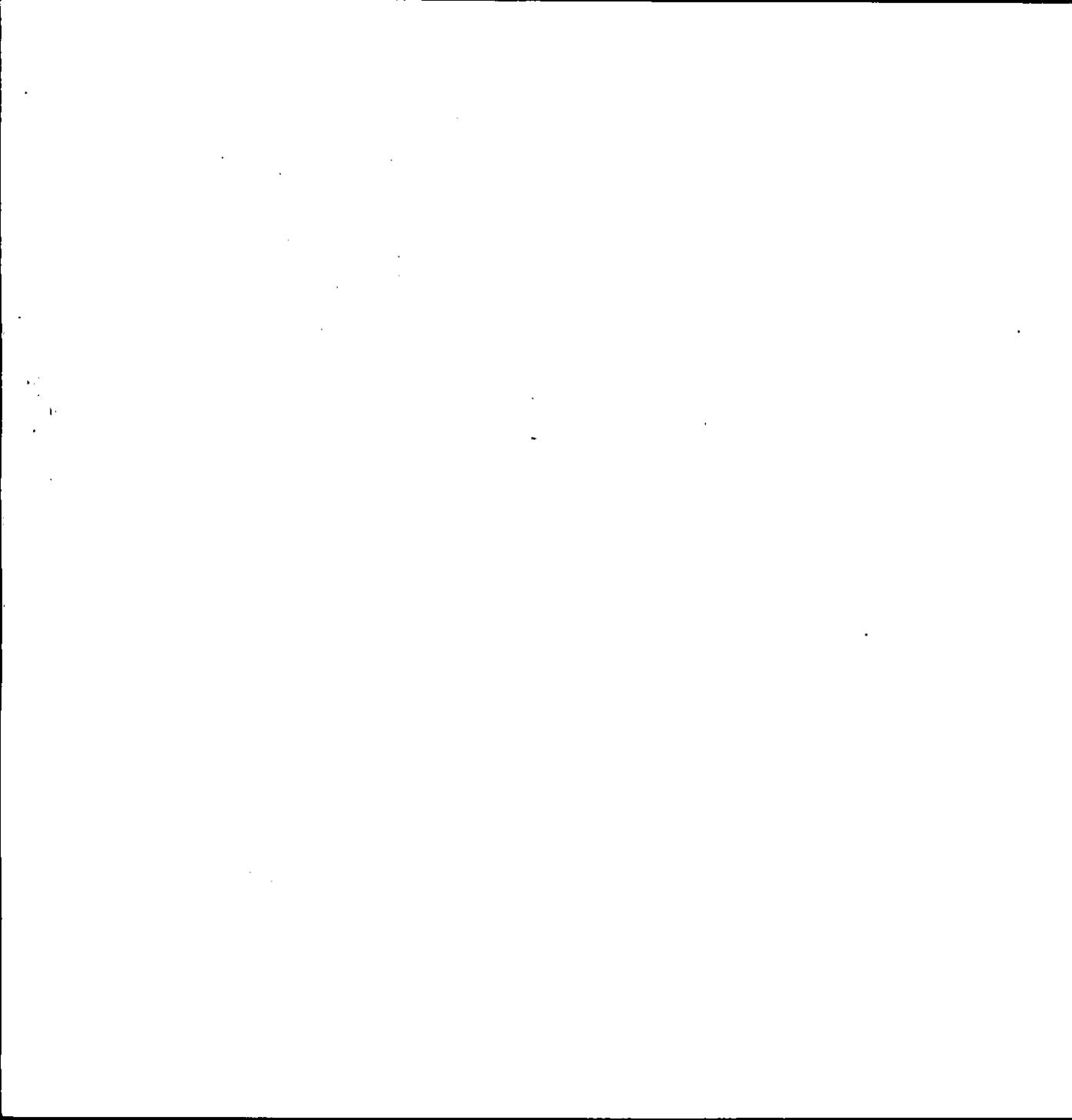
WHAT TEST CONFIRMED DIAGNOSIS? *Physical*
(Signed) *J. H. Mitchell*, M. D.

Feb. 14 1929 (Address) *Rolla Mo*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Rolla Cemetery* DATE OF BURIAL *Feb. 14 1929*

20. UNDERTAKER *H. R. McCaw* ADDRESS *Rolla, Mo*



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BUREAU OF VITAL STATISTICS
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ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Phelps Registration District No. 697 File No.
Township Primary Registration District No. 4403 Registered No. 22
City Polla (No.) St. Ward)

2. FULL NAME

Gladys Eugenia Castleman
(a) Residence No. St. Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*) M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 30 - 1906

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>22</u>	<u>8</u>	<u>13</u>		

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14. INFORMANT
(Address)

15. FILED June 10, 1929 Joe. F. Ayers REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 13 1929

17. I HEREBY CERTIFY That I attended deceased from
....., 19..... to
that I last saw h..... alive on 19....., and that
death occurred, on the date stated above, at

THE CAUSE OF DEATH WAS AS FOLLOWS:

.....
..... (duration) yrs. mos. ds.
.....
.....
..... (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed), M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

S-4539

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