

No. 2  
9-4-41  
17-33

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

34782

NOV 6 1943

Registration District No. 132

Primary Registration District No. 3021

State File No. ....

Registrar's No. 140

1. PLACE OF DEATH:

(a) County Grundy  
(b) City or town IRENTON  
(c) Name of hospital or institution:  
1730 PLEASANT PLAIN ST.  
(d) Length of stay: In hospital or institution 9 years  
In this community 9 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Grundy 40  
(c) City or town IRENTON  
(d) Street No. 1730 PLEASANT PLAIN  
(e) Citizen of foreign country? No

3. (a) PRINT FULL NAME NELLIE G CASTEEL

3. (b) If veteran, name war. .... 3. (c) Social Security No. NONE

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced, Widowed  
6. (b) Name of husband or wife WILLIAM G CASTEEL 6. (c) Age of husband or wife if alive — years  
7. Birth date of deceased. April 29 1870

8. AGE: Years 73 Months 03 Days 18 If less than one day hr. min.

9. Birthplace New York City New York

10. Usual occupation Housewife

11. Industry or business HOME

MOTHER FATHER  
12. Name John J. Tracy  
13. Birthplace unknown New York  
14. Maiden name ANNA WILLIAMSON  
15. Birthplace unknown New York

16. (a) Informant Don E Casteel

(b) Address 2 North Missouri

17. (a) Burial (b) Date thereof 10-16-43  
(c) Place: burial or cremation St Johns, Mo.

18. (a) Signature of funeral director Rafael A Davis

(b) Address St Johns Mo.

19. (a) 10-20-43 (b) L Roberts

(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 13th  
year 1943 hour 1:00 minute 7 M.

21. I hereby certify that I attended the deceased from October 8th 1943 to Oct 13 1943

that I last saw him alive on October 13 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia 2 days

Due to .....

Due to .....

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations .....

Of autopsy .....

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) .....

(b) Date of occurrence .....

(c) Where did injury occur? (City or town) (County) (State) .....

(d) Did injury occur in or about home, on farm, in industrial place, in public place? .....

While at work? (Specify type of place) (e) Means of injury .....

23. Signature Douglas L Pearson (Registrar or other) D.O.

Address Trenton Mo Date signed 10/18/43

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

**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.....  
*My self.*....., Registered Apprentice No.....  
working under my personal supervision.

Signed

*Raymond A. Wain*

Licensed Embalmer No.

*3424*

P. O. Address

*Denton, 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 this body is not embalmed, fact should be so stated above.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. *no*

Registration District No. *132*

Primary Registration District No. *3021*

Registrar's No. *140*

1. PLACE OF DEATH:  
(a) County *Cassidy*  
(b) City or town *Trenton*  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME *Nellie G. Casteel*  
3. (b) If veteran, name war \_\_\_\_\_  
3. (c) Social Security No. \_\_\_\_\_

4. Sex *F* 5. Color or race *W*  
6. (a) Single, widowed, married, divorced *W*

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased *Jan 25 1917*  
(Month) (Day) (Year)

8. AGE: Years *73* Months *3* Days *7* If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month *Oct* Day *3* Year *1943* Hour \_\_\_\_\_ Minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death *Pneumonia, Toxic* Duration *2 days*

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_ (include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature *Daughes S. Pearce* (M. D. or other) *D.O.*  
Address *705 Main Trenton* Date signed *10/5/43*

MOTHER, FATHER

**SUPPLEMENTARY**

*108*

PHYSICIAN

Underline the cause to which death should be charged statistically.

34782