

FILED MAY 7 1947

Registration District No. 300Primary Registration District No. 3058Registrar's No. 63

## 1. PLACE OF DEATH:

(a) County St Charles  
 (b) City or town St Charles  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution St Joseph Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution Three days  
 (Specify whether  
 In this community Life  
 years, months or days)

3. (a) PRINT  
FULL NAMECalvin Castlio3. (b) If veteran,  
name war No3. (c) Social Security  
No. None4. Sex M  
5. Color or  
race W6. (a) Single, widowed, married,  
divorced widowed

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if  
alive \_\_\_\_\_ years7. Birth date of deceased Nov. 9 1856  
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day  
90 5 14 hr. min.9. Birthplace St Charles Co.  
(City, town, or county) (State or foreign country)10. Usual occupation Retired Farmer

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

12. Name Jasper Neuton Castlio13. Birthplace St Charles, Co  
(City, town, or county) (State or foreign country)14. Maiden name Manalie Keithly15. Birthplace St Charles Co  
(City, town, or county) (State or foreign country)16. (a) Informant Jas R. Castlio(b) Address Liberty, Mo.17. (a) Burial (b) Date thereof 4-25-47  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Howell Cem18. (a) Signature of funeral director Marvin Munday(b) Address Wentzville, Mo19. (a) 4-26-47 (b) Fannie Hamelton  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St Charles, 9th  
 (c) City or town Rural  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_ (If rural, give location) 0  
 (e) Citizen of foreign country? Yes (Yes or No)  
 If yes, name country \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr. day 23  
year 1947 hour 3:20 minute X M.21. I hereby certify that I attended the deceased from Apr. 20, 1947 to 4-23, 1947  
that I last saw h. \_\_\_\_\_ alive on 4-23, 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac  
Decompensation (Fibrillation)  
Hypostatic pneumonia  
 Due to Generalized Hypertension  
due to generalized arteriosclerosis  
 Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

## PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged statistically.

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?

(Specify type of place)  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_23. Signature George R. Basak (M. D. or other) 0  
Address St Charles Hotel Bldg Date signed 4-26-47

RECEIVED  
District Health Officer No. 9,  
District File Number \_\_\_\_\_  
Date Filed \_\_\_\_\_

MAY 8 1947

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 \_\_\_\_\_

\_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_,  
working under my personal supervision.

Signed *Marie M. Muehlenberg*

Licensed Embalmer No. *2461*

P. O. Address *Wentzville*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

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

Registration District No. 310

Primary Registration District No. 3058

1. PLACE OF DEATH:

(a) County St Charles  
(b) City or town St Charles  
(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 years, months or days)

3. (a) PRINT FULL NAME Calvin Castle

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced wid

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

7. Birth date of deceased nov 9 1947  
(Month) (Day) (Year)

8. AGE: Years 90 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min. \_\_\_\_\_

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

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) April 26-47 \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County St Charles  
(c) City or town Rural  
(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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April Day 23 Year 1947 (hour) \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Duration

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

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

Of autopsy \_\_\_\_\_

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

14716