

FILED SEP 23 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

30145

State File No. \_\_\_\_\_

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. <u>3884</u>	
1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Kansas City</u>		c. LENGTH OF STAY (in this place) <u>18 yrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Kansas City</u>		3. <u>29</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Clark Conv. Home</u>				d. STREET ADDRESS (If rural, give location) <u>1737 Washington</u>			
3. NAME OF DECEASED a. (First) <u>Frank</u>		b. (Middle)		c. (Last) <u>CASTATOR</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>8</u> Year <u>1949</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Wh.</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Dec. 25, 1869</u>	
9. AGE (In years last birthday) <u>79</u>		10. UNDER 1 YEAR Months _____ Days _____		11. UNDER 100 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rec. Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Woolf Bros.</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Ind.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Wm. Castator</u>		13b. MOTHER'S MAIDEN NAME <u>Serah Hobson</u>		14. NAME OF HUSBAND OR WIFE <u>Gladys Castator</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>490-16-9705</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Gladys Castator, 1737 Washington, KC</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Uremia</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Generalized Arterial Sclerosis</u>  DUE TO (c)  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Dementia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 Weeks-2</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION  <u>4500</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5 Sept.</u> , 1949, to <u>8 Sept.</u> , 1949, that I last saw the deceased alive on <u>28 Sept.</u> , 1949, and that death occurred at <u>8</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>Robert M. Myers</u> (Degree or title)				23b. ADDRESS <u>M.D. 1025 Rialto Bldg</u>		23c. DATE SIGNED <u>8 Sept 49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		24b. DATE <u>9-10-49</u>		24c. NAME OF CEMETERY OR CREMATOR <u>Elmwood Crematory</u>		24d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>9-9-49</u>		REGISTRAR'S SIGNATURE <u>Sheraldine Holmes</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Hollody-McGilley-Eylar, K.C., Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

Dr. Robt. M. Meyers

Rialto - V. 4751

until 5:30 Thrus

11 — 4:30 Fri

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 .....  
Student Embalmer

Signed

*Max H. Kirkendall*

Licensed Embalmer No.

*4632*

P. O. Address

*A. C. 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.