

FILED JAN 9 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 43529

BIRTH NO. _____ REG. DIST. NO. 362 PRIMARY REG. DIST. NO. 4531 Registrar's No. 62

1. PLACE OF DEATH a. COUNTY <u>Warren</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Charles</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Warrenton</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Augusta, Mo.</u>	
c. LENGTH OF STAY (In this place) <u>15 days</u>		d. STREET ADDRESS (If rural, give location) <u>?</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Katie Jane Memorial Home</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>UNCA'SIO</u> b. (Middle) <u>MCCLURE</u> c. (Last) <u>CASTLIO</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Nov 29 1949</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widower</u>	8. DATE OF BIRTH <u>Mar 15</u>
9. AGE (In years last birthday) <u>84</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 11 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARM HAND</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <u>St. Charles Co., Mo.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13a. FATHER'S NAME <u>OTHANIAL C. CASTLIO</u>		13b. MOTHER'S MAIDEN NAME <u>C. KIETHLY</u>	14. NAME OF HUSBAND OR WIFE <u>WIDOWER</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'S SIGNATURE OR NAME ADDRESS <u>Mrs RAY OLIVER, St. Charles, Mo</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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral hemorrhage recurrent</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Pneumonia Hypostatica</u> DUE TO (c) <u>bilateral</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Hypertensive cardio-vascular renal disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) <u>331X</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____	21e. INJURY OCCURRED WHILE AT 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>Nov 4</u> , 19 <u>49</u> , to <u>Nov 29</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>Nov 29</u> , 19 <u>49</u> , and that death occurred at <u>6:30 P.m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>Donald Storch</u>		23b. ADDRESS <u>Warrenton Mo</u>	23c. DATE SIGNED <u>Dec 1 1949</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>	24b. DATE <u>DEC 8 - 49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>OAK GROVE CEMETARY</u>	24d. LOCATION (City, town, or county) (State) <u>ST. LOUIS Mo</u>
DATE REC'D BY LOCAL REG. <u>12-21-49</u>	REGISTRAR'S SIGNATURE <u>Floyd Logan</u>	421	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Morris Muehlberg</u>

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

District File Number _____
District Health Officer No. 9,
RECEIVED JAN 4 1950

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 _____

working under my personal supervision.

Student
Student Embalmer

Student Embalmer No. _____

Signed *Marjorie Murchison*
Marjorie Murchison

Licensed Embalmer No. *2461*

P. O. Address *Wentzville 7*

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.