

FILED DEC 24 1952

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BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis, Missouri</u>		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St Louis</u>		2219	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Louis City Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>1922a Ofallon</u>			
3. NAME OF DECEASED (Type or Print) <u>BACILIO CASTRO</u>		a. (First)		b. (Middle)		c. (Last)	
4. DATE OF DEATH <u>NOVEMBER 26, 1952</u>		4. DATE OF DEATH (Month) (Day) (Year)		4. DATE OF DEATH (Month) (Day) (Year)		4. DATE OF DEATH (Month) (Day) (Year)	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>W</u>		8. DATE OF BIRTH <u>June 14-86</u>		9. AGE (In years last birthday) <u>66</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cemante Finisher</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <u>Mexco</u>		12. CITIZEN OF WHAT COUNTRY? <u>Yes</u>	
13a. FATHER'S NAME <u>Louis Castro</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Deceased</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY (If yes, give war or dates of service) <u>494-36-3598</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs Lucille Stabile</u>		ADDRESS <u>3924 Nebraska</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>Massive Interventricular Cerebral Hemorrhage</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertension</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input checked="" 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)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>331X</u>					
22. I hereby certify that I attended the deceased from <u>11-24-52</u> , 19 <u>52</u> , to <u>11-26-52</u> , 19 <u>52</u> , that I last saw the deceased alive on <u>11-26-52</u> , 19 <u>52</u> , and that death occurred at <u>10:55A</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Wm Huggins, MD</u>				23b. ADDRESS <u>1515 Lafayette Avenue</u>		23c. DATE SIGNED <u>11-26-52</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>11-29-52</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St Louis Mo</u>	
DATE REC'D BY LOCAL REG. <u>NOV 28 1952</u>		REGISTRAR'S SIGNATURE <u>J. Charles Smith MD</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Central Funeral Home</u>		ADDRESS <u>1841 Cass</u>	

WRITE PLAINLY—USING 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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

Fred J. Farmer
Licensed Embalmer No. *4988*

P. O. Address *St. Louis, 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.