

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 19269
4945
Registrar's No.

318

1003

FILED JUN 1 - 1953

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. 1003		Registrar's No. _____			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois b. COUNTY St. Clair					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. LENGTH OF STAY (In this place) _____		c. CITY OR TOWN O'Fallon		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital				e. STREET ADDRESS (If rural, give location) R.R. #2					
3. NAME OF DECEASED (Type or Print) MATILDA			a. (First) _____ b. (Middle) _____ c. (Last) CASTIAUX			4. DATE OF DEATH (Month) (Day) (Year) MAY 14, 1953			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH Dec 25 1869			
9. AGE (In years last birthday) 83		if UNDER 1 YEAR Days _____		if UNDER 10 HRS. Hours _____		if UNDER 15 MIN. Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (City and State or Foreign Country) Belgium		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13a. FATHER'S NAME Unknown Bordin			13b. MOTHER'S MAIDEN NAME Rosalie Unknown			14. NAME OF HUSBAND OR WIFE Emil Castiaux			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No Nil			16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Mrs. Julia Ryan, O'Fallon, Illinois			ADDRESS _____	
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) Cerebral Vascular Neurology ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) Cerebral arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH _____	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Squamous Cell Carcinoma				19a. DATE OF OPERATION _____				19b. MAJOR FINDINGS OF OPERATION _____	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		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 WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 331XH					
22. I hereby certify that I attended the deceased from 5-5-53 , 19____, to 5-14-53 , 19____, that I last saw the deceased alive on 5-14-53 , 19____, and that death occurred at 9:00P m. , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) Albert E. Stock MD				23b. ADDRESS 1515 Lafayette Avenue		23c. DATE SIGNED 5-15-53			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 5-18-53		24c. NAME OF CEMETERY OR CREMATORY College Hill		24d. LOCATION (City, town, or county) (State) Labanon, Illinois.			
DATE REC'D BY LOCAL REG. MAY 16 1953		REGISTRAR'S SIGNATURE J. Earl Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe, 4700 Washington					

(Licensed Embalmer's Statement on Reverse Side)

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.....
Signature of Student Embalmer

Signed *John S. Allen*.....

Licensed Embalmer No. *1234*

P. O. Address *St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.