

Health,
Welfare
Public
Service

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
Frank B. Wallace

FILED SEP 21 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30627
STATE FILE NUMBER
3803

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

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, give TOWNSHIP only) OR TOWN <u>Kansas City 1</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Kansas City 3748</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>4811 Charlotte</u> Length of stay in lb <u>49 yrs.</u>		d. STREET ADDRESS (If outside, give location) <u>4811 Charlotte</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Louy</u> Middle <u>Garrett</u> Last <u>Castle</u>	4. DATE OF DEATH Month <u>August</u> Day <u>27</u> Year <u>1956</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 23, 1886</u>	9. AGE (In years last birthday) <u>69</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Public Service</u>	11. BIRTHPLACE (City and state or country) <u>Abingdon, Virginia</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13. FATHER'S NAME <u>Jake Castle</u>	14. MOTHER'S MAIDEN NAME <u>Andelia Burke</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no none</u>	16. SOCIAL SECURITY NO. <u>486-03-1845</u>	17. INFORMANT Address <u>4811 Charlotte K.C., Mo.</u> <u>Mrs. Mabel Castle</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 da</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Arterial Hypertension</u>	<u>10 yrs</u>
	DUE TO (c) <u>+ stroke</u>	<u>3-4 h</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour <u>5:40 P.</u> Month <u>8</u> Day <u>27</u> Year <u>1956</u> a. m. <u>p. m.</u>	

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>Kansas City Jackson MO</u>
21. I attended the deceased from <u>1940</u> to <u>8-27-56</u> and last saw him alive on <u>8-27-56</u> Death occurred at <u>5:40 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Degree or title) <u>Frank B. Wallace, MD</u>	22b. ADDRESS <u>1215 Puerto Bldg</u>	22c. DATE SIGNED <u>8/28/56</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>AUG. 30, 1956</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT. MORIAN CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>KANSAS CITY MISSOURI</u>
24. FUNERAL DIRECTOR <u>D.W. Newcomer's Sons</u>	ADDRESS <u>1381 Brook Creek K.C., MO-</u>	25. DATE RECD. BY LOCAL REG. <u>8-30-56</u>	26. REGISTRAR'S SIGNATURE <u>Neva Minshall</u>

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... *Paul B. Williamson*

Licensed Embalmer No. *500*

P. O. Address *K.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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.