

FILED AUG 6 1948
Registration District No. 128

Primary Registration District No. 5466

1. PLACE OF DEATH:
(a) County GREENE
(b) City or town S. Campbell Twp. RURAL
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Medical Center for Federal Prisoners
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 yr, 6 mos, 10 days
In this community 1 yr, 6 mos, 10 days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Illinois (b) County Champaign
(c) City or town Philo
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME TOWNER, Paul B. #5965-H
3. (b) If veteran, name war World War I 3. (c) Social Security No. ?

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day 21 year 1948 hour 11 minute 20 A.M.
21. I hereby certify that I attended the deceased from January 11, 1947 to July 21, 1948 that I last saw him alive on July 21, 1948 and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Pearl Hammond 6. (c) Age of husband or wife if alive 45 years
7. Birth date of deceased July 23 1899
(Month) (Day) (Year)

Immediate cause of death Cardiac failure Duration _____

8. AGE: Years Months Days If less than one day
48 11 28 hr. _____ min.

Due to Arteriosclerotic heart disease with Stokes-Adams syndrome.

9. Birthplace Philo Illinois
(City, town, or county) (State or foreign country)

Due to _____

10. Usual occupation Unknown

Other conditions Tuberculosis of lung, moderately advanced; Fistula, bronch-

11. Industry or business _____

Major findings: pleural, tuberculous Of operations _____

12. Name Samuel W. Towner

13. Birthplace ? Illinois-?
(City, town, or county) (State or foreign country)

14. Maiden name Maud B. Anderson

15. Birthplace ? ?
(City, town, or county) (State or foreign country)

16. (a) Informant File

(b) Address MCFP

17. (c) Burial (b) Date thereof July 23 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation East Lawn Cemetery

18. (a) Signature of funeral director Fred C. Thieme

(b) Address Springfield, Mo.

19. (a) 7-28-48 (b) M. E. Handley M.D.
(Date received local registrar) (Registrar's signature)

Of autopsy Tuberculosis of lungs

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature E. R. Smith (M. D. JESSEY)
Address Medical Center Fed. Pris. Date signed 7-21-48

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

MOTHER, FATHER

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed..... *Ralph A. Linn*

Licensed Embalmer No. *3681*

P. O. Address *Springfield, 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.