

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **16300**
4033
Registrar's No. _____

FILED MAY 14 1953

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place) 2 weeks	c. CITY OR TOWN Doniphan 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 3909 West Pine		e. STREET ADDRESS (If rural, give location) Rural Route 0910	
3. NAME OF DECEASED (Type or Print) John		a. (First) John	b. (Middle) Towell
c. (Last) Towell		4. DATE OF DEATH (Month) (Day) (Year) 4-17-53	
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 6-7-1877
9. AGE (In years last birthday) 75		IF UNDER 1 YEAR Months	IF UNDER 2 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired farmer		10b. KIND OF BUSINESS OR INDUSTRY farm	11. BIRTHPLACE (City and State or Foreign Country) Carmi, Ill.
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Ben Towell	
13b. MOTHER'S MAIDEN NAME Martha Doughboard		14. NAME OF HUSBAND OR WIFE Sarah Towell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mollie Anglin, 3909 W. Pine
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ ANTECEDENT CAUSES Coronary Thrombosis DUE TO (b) _____ DUE TO (c) _____ Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 4201		22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 12:55 P. m. , from the causes and on the date stated above.	
23a. SIGNATURE (Do not print title) J. Earl Smith, M.D.		23b. ADDRESS 1300 Clark	
23c. DATE SIGNED 4/18/53		24a. BURIAL, CREMATION, REMOVAL (Specify) removal	
24b. DATE 4-18-53		24c. NAME OF CEMETERY OR CREMATORY	
24d. LOCATION (City, town, or county) (State) Doniphan, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Black and Edwards, Doniphan, Mo.	
DATE REC'D BY LOCAL REG. APR 18 1953		REGISTRAR'S SIGNATURE J. Earl Smith, M.D.	

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

M. W. Ruster

Licensed Embalmer No. *4865*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.