

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-023471

STATE FILE NUMBER  
24679

FILED JUN 19 1959

Registration District No. Primary Registration District No.

300  
1-57  
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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Missouri.</b>		c. CITY OR TOWN <b>Olivette</b> <b>4381</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Jewish Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>9626 Old Bonhomme Rd.</b>	

3. NAME OF DECEASED (Type or print) First <b>Louis</b> Middle Last <b>Towley</b>			4. DATE OF DEATH Month <b>May</b> Day <b>12</b> Year <b>1959</b>		
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 4, 1904</b>	9. AGE (In years last birthday) <b>55</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School Teacher</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Schools</b>	11. BIRTHPLACE (City and state or country) <b>St. Peter, Minnesota.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Gabriel Towley</b>	13b. MOTHER'S MAIDEN NAME <b>Victoria Almen</b>	14. NAME OF HUSBAND OR WIFE <b>Marie Towley</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>199-34-1055</b>	17. INFORMANT Address <b>Marie Towley, 9626 Old Bonhomme Road.</b>
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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) <b>Cerebral hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 hours</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Hypertensive heart disease</b>		<b>1 year</b>
	DUE TO (c) <b>Arteriosclerotic heart disease</b>		<b>1 year</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Chromophobe adenoma of pituitary</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	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
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21. I attended the deceased from <b>March 23, 1959</b> to <b>May 12, 1959</b> and last saw her alive on <b>May 12, 1959</b> Death occurred at <b>7 P.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <b>Llewellyn Dale Jr M.D.</b>	22b. ADDRESS <b>100 North Euclid, St. Louis,</b>	22c. DATE SIGNED <b>Mo. 5/13/59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>5-13-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Local</b>	23d. LOCATION (City, town, or county) (State) <b>St. Peter, Minnesota.</b>
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24. FUNERAL DIRECTOR ADDRESS <b>Albert H. Hoppe, 4700 Washington Blvd.,</b>	25. DATE RECD. BY LOCAL REG. <b>MAY 13 '59</b>	26. REGISTRAR'S SIGNATURE <b>Mrs. Pearl Smith. M.D.</b>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related. All diseases in Part I must be causally related. All diseases in Part I must be causally related.

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

Signature *Stanley A. Dixon*  
Licensed Embalmer No. *4193*  
P. O. Address *St. L.*

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.