

**FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-003544**

**FILED VS FEB 5 1960**

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 923** STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY _____ b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Mo.</b> Length of stay in 1b _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Louis City Hosp. # 1</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri.</b> b. COUNTY _____ c. CITY OR TOWN <b>St. Louis.</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <b>604 Chestnut, St.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				
<b>3. NAME OF DECEASED</b> (Type or print) First <b>WILLIAM</b> Middle <b>A.</b> Last <b>HIGHTOWER</b>				<b>4. DATE OF DEATH</b> Month <b>Jan.</b> Day <b>25</b> Year <b>1960</b>				
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input checked="" type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>10/10/1889</b>	<b>9. AGE (last birthday)</b> <b>70</b>	<b>IF UNDER 1 YEAR</b> Months _____ Days _____	<b>IF UNDER 24 HR</b> Hours _____ Min. _____		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired Clerk Butler Bros.</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> _____		<b>11. BIRTHPLACE</b> (City and state or country) <b>Illinois.</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.A.</b>		
<b>13a. FATHER'S NAME</b> <b>Andrew Hightower</b>			<b>13b. MOTHER'S MAIDEN NAME</b> <b>Angeline Hunt</b>			<b>14. NAME OF HUSBAND OR WIFE</b> <b>Nil.</b>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes</b> <b>W. W. # 1</b>			<b>16. SOCIAL SECURITY NO.</b> <b>Unknown</b>		<b>17. INFORMANT</b> Address <b>Mrs. Ed. Faires, St. Jacob, Illinois.</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b> DUE TO (b) _____ DUE TO (c) <b>420.1</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <b>3 HRS</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Psychotic Depressive Reaction</b>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		<b>20a. ACCIDENT SUICIDE HOMICIDE</b> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.) _____				
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY _____ STATE _____		
<b>21. I attended the deceased from</b> <b>12/20/59</b> to <b>1/25/60</b> and last saw him alive on <b>1/25/60</b> Death occurred at <b>2:35 p.m.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.								
<b>22a. SIGNATURE</b> (Degree or title) <b>Nicholas Owen M.D.</b>				<b>22b. ADDRESS</b> <b>1515 Lafayette Ave.</b>		<b>22c. DATE SIGNED</b> <b>1/25/60</b>		
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Removal</b>		<b>23b. DATE</b> <b>1-28-60</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Keystone Cemetery</b>		<b>23d. LOCATION</b> (City, town, or county) (State) <b>St. Jacob, Illinois.</b>		
<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>Albert H. Hoppe Inc., 4700 Washington, Blvd</b>				<b>25. DATE RECD. BY LOCAL REG.</b> <b>JAN 26 1960</b>		<b>26. REGISTRAR'S SIGNATURE</b> <b>Paul Smith M.D.</b>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Lawrence M. Bell

Licensed Embalmer No. 4375

P. O. Address St Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.