

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-043206

NOV 3 0 1960

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 235 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>ST. CHARLES</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>ST. CHARLES</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. CHARLES</u>		Length of stay in 1b <u>10 YRS</u>		c. CITY OR TOWN <u>ST. CHARLES</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>ST. JOSEPH'S HOSP.</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>921 So. 3RD</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>R</u> Last <u>TOWERS</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>23</u> Year <u>1960</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</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 7 1875</u>	9. AGE (last birthday) <u>85</u>	IF UNDER 1 YEAR Months <u>2</u> Days _____ Hours _____ Min. _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>		11. BIRTHPLACE (City and state or country) <u>ST. CHARLES Co. Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>GEORGE TOWERS</u>			13b. MOTHER'S MAIDEN NAME <u>MARIAMNE MILLER</u>		14. NAME OF HUSBAND OR WIFE <u>MINNIE WALKER TOWERS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>MINNIE TOWERS.</u>		Address <u>ST. CHARLES, Mo</u>		
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>Acute Pulmonary Congestion</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) DUE TO (b) <u>myocardial failure</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Fracture left femur, Barocystic illness</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>		
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 _____ s.m. _____ p.m. _____		Month, Day, Year						
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		
21. I attended the deceased from <u>July 1955</u> to <u>Nov 23 60</u> and last saw him alive on <u>Nov 23-1960</u> Death occurred at <u>6:50 P.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>Vincent W. Schumaker M.D.</u>				22b. ADDRESS <u>St Charles, Mo</u>		22c. DATE SIGNED <u>11-25-60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>Nov. 26, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LINN CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>WENTZVILLE, Mo</u>			
24. FUNERAL DIRECTOR <u>C.L. PRINSTER.</u>			ADDRESS <u>ST. CHARLES Mo</u>		25. DATE RECD. BY LOCAL REG. <u>Nov. 26-60</u>	26. REGISTRAR'S SIGNATURE <u>Maicella Wilson</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1961 8 17 57

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

Howard O. Kishner

Licensed Embalmer No. 463

P. O. Address Wentzville

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.