

N. B.—Every item of information should be carefully supplied. **AGE** should be stated **EXACTLY**. **PHYSICIANS** should state **CAUSE OF DEATH** in plain terms, so that it may be properly classified. **Exact statement of OCCUPATION** is very important.

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

PLACE OF DEATH

County Neosho  
Township Neosho  
or  
Village  
or  
City (NO. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

*[Handwritten initials]*

Registration District No. 6-109 File No. 2629  
Primary Registration District No. 6-898 Registered No. 143

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME James M. Gowen

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Male COLOR OR RACE White SINGLE married  
MARRIED WIDOWED OR DIVORCED (Write the word)

DATE OF DEATH Jan 18, 1911  
(Month) (Day) (Year)

DATE OF BIRTH April 30, 1871  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 23<sup>rd</sup>, 1910, to Jan 18, 1911, that I last saw him alive on Jan 8<sup>th</sup>, 1911, and that death occurred, on the date stated above, at 10 A m. The CAUSE OF DEATH was as follows:

AGE 39 yrs. 8 mos. 19 ds. If LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.?

2.3A Empyema  
110A [Handwritten]

OCCUPATION (a) Trade, profession, or particular kind of work Farm Merchant  
(b) General nature of industry, business, or establishment in which employed (or employer) [Handwritten]

BIRTHPLACE (City or town, State or foreign country) St Louis County Mo

(Duration) \_\_\_ yrs. 2 mos. \_\_\_ ds.  
Contributory Pulmonary tuberculosis  
(SECONDARY) (Duration) 2 yrs. \_\_\_ mos. \_\_\_ ds.

NAME OF FATHER Wm Gowen

(Signed) R L Lamm M. D.  
Jan 20 1911 (Address) Neosho Mo

BIRTHPLACE OF FATHER (City or town, State or foreign country) Tenn

MAIDEN NAME OF MOTHER Susan Gisch

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.  
LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
At place of death \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds. In the State \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.  
Where was disease contracted if not at place of death?

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Jefferson City Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Former or usual residence

(ADDRESS) Mrs Wm Gowen

PLACE OF BURIAL OR REMOVAL St. John's Cemetery DATE OF BURIAL July 20, 1911

Filed 1-19 1911 Dr. J. D. S. McNeal REGISTRAR

UNDERTAKER [Handwritten] ADDRESS

# Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health  
Association]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sar-*

*coma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)



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MISSOURI STATE BOARD OF HEALTH

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

PLACE OF DEATH  
County Newton  
Township Neesh  
or  
Village \_\_\_\_\_  
or  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St.: \_\_\_\_\_ Ward)

Registration District No. 609 File No. 2629  
Primary Registration District No. 5808 Registered No. \_\_\_\_\_

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME James M. Gowen

PERSONAL AND STATISTICAL PARTICULARS

SEX M. COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED Married  
(Write the word)

DATE OF BIRTH 4/30, 1871  
(Month) (Day) (Year)

AGE 39 yrs. 8 mos. 19 ds. IF LESS than 1 day, \_\_\_\_ hrs. or \_\_\_\_ min.?

OCCUPATION (a) Trade, profession, or particular kind of work Farmer Merchant  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

BIRTHPLACE (City or town, State or foreign country) St Louis Mo

NAME OF FATHER Wm Gowen

BIRTHPLACE OF FATHER (City or town, State or foreign country) St Louis Mo

MAIDEN NAME OF MOTHER Susan Beach

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Jefferson City Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Wm Alma Gowen  
(ADDRESS) Neosho Mo

Filed Jan 19 x 1911 2 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH \_\_\_\_\_ 18, 1911  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 12/23, 1911, to 1-18, 1911, that I last saw him alive on 1-8, 1911, and that death occurred, on the date stated above, at 10 a.m.  
The CAUSE OF DEATH\* was as follows:

Pneumonia

Contributory (SECONDARY) Pulmonary Tuberculosis  
(Duration) 2 yrs. 2 mos. 0 ds.  
(Signed) R. C. Lawson M. D.  
1-20 1911 (Address) Neosho Mo

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted if not at place of death?  
Former or usual residence \_\_\_\_\_

PLACE OF BURIAL OR REMOVAL Wells Cem. DATE OF BURIAL 1-20 1911  
UNDERTAKER F. J. Bergman Co. ADDRESS Neosho Mo

JAN-19-11 All information called for must be written on this Supplementary Certificate.

# Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health  
Association]

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