

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

1 PLACE OF DEATH

County Johnson

Township Warrensburg

Village Warrensburg

City Warrensburg (NO. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

Registration District No. 431

File No. 13111

Primary Registration District No. 3023

Registered No. 26

2 FULL NAME William Menefee Gowin

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

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W 5 SINGLE MARRIED WIDOWED OR DIVORCED Widowed  
(Write the word)

6 DATE OF BIRTH Jan. 24, 1832  
(Month) (Day) (Year)

7 AGE 83 yrs. 2 mos. 12 ds. If LESS than 1 day, hrs. or min.?

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

9 BIRTHPLACE (City or town, State or foreign country) Kentucky

10 NAME OF FATHER Unknown  
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Unknown  
12 MAIDEN NAME OF MOTHER Unknown  
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Grant Gowin  
(Address) Montserrat, Mo.

15 Filed Apr 7 1915 D. C. Carson Registrar

3 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 6<sup>th</sup> 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from April 4<sup>th</sup> 1915 to April 6<sup>th</sup> 1915  
that I last saw him alive on April 4<sup>th</sup> 1915  
and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH\* was as follows:  
131 Alumina  
113 Other cause was known

18 DURATION (Duration) yrs. mos. ds. 3 ds.

CONTRIBUTORY (Secondary) Lapsing  
(Duration) yrs. mos. ds. 15 ds.

(Signed) O. B. Hull M. D.  
Apr. 6<sup>th</sup> 1915 (Address) Warrensburg, Mo.

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

18 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 \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Pleasant Point DATE OF BURIAL April 7, 1915

20 UNDERTAKER J. M. M. Meekin ADDRESS Warrensburg, Mo.

N. B. - Eye CAUSE

# 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, peritonaeum*, etc., *Carcinoma, Sarcoma*, 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.)

## PLACE OF DEATH

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

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

County

Johnson

Township

Registration District No.

431

File No.

or

Village

Primary Registration District No.

3023

Registered No.

26

or

City

Warrensburg

NO.

St.:

Ward)

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

FULL NAME

William Mentefer Gowin

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

SEX

M

COLOR OR RACE

W

SINGLE  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

N

DATE OF DEATH

(Month)

4/6

1915  
(Day) (Year)

DATE OF BIRTH

Satisfactory Information Supplied  
(Month) (Day) (Year)

AGE

Satisfactory Information Supplied  
yrs. mos. ds.IF LESS than  
1 day, hrs.  
or min.I HEREBY CERTIFY, that I attended deceased from  
to  
that I last saw h. alive on  
and that death occurred, on the date stated above at  
The CAUSE OF DEATH\* was as follows:

OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Chronic nephritis

BIRTHPLACE

(City or town, State or foreign country)

Contributory

(SECONDARY)

Cl. B. Hall  
(Duration) yrs. mos. ds.

PARENTS

NAME OF FATHER

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

MAIDEN NAME OF MOTHER

BIRTHPLACES OF MOTHER  
(City or town, State or foreign country)(Signed) J. J. [Signature] M. D.  
H/ [Signature] 1915 (Address) Warrensburg

\*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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(ADDRESS)

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

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Filed

Apr 7 1915

D. Cadeick  
REGISTRAR

UNDERTAKER

ADDRESS

Original file, date

APR - 1915

19

All information called for must be written on this Supplementary Certificate.

CAUTION: Item of information should be carefully studied. AGE should be stated FULLY. PHYSICIANS should state FULLY. PLACE OF DEATH in plain terms. Satisfactory Information Supplied.

SUPPLEMENTARY

# Revised United States Standard Certificate of Death

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