1929

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

Do not use this space.

40286

1. PLACE OF DEATH
County: Greene
Township:
City: Springfield (No. R#4 St. Ward)
Registration District No. 318
Primary Registration District No. 5439
File No.
Registered No. 836

2. FULL NAME: Tom Gower
(a) Residence. No. R#4 St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widower

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Unknown 1865

7. AGE: Years 63 | Months Unknown | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired Machinist Helper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Mo.

PARENTS
10. NAME OF FATHER: Josiah Gower
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Tenn.
12. MAIDEN NAME OF MOTHER: Emaline Anderson
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Tenn.

14. INFORMANT: Dan Gower
(Address) Springfield, Mo.

15. FILED 12-1, 1928 A. C. Horst M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Dec 1 1928

17. I HEREBY CERTIFY, That I attended deceased from Oct. 30, 1928, to Nov 30, 1928 that I last saw him alive on Nov 25, 1928, and that death occurred, on the date stated above, at 3 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

95L Paralysis
82A L
97 (duration) yrs. mos. 15 ds.

CONTRIBUTORY (SECONDARY): Cardio-Renal Disease Arterio-Sclerosis
Did not Know (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
8 DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) Chas A. George, M.D.
, 19 (Address) 710 Woodruff Bldg Springfield Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Green Lawn Cemetery
DATE OF BURIAL: Dec 2 1928

20. UNDERTAKER: J. W. Klingner & Co. Coml
ADDRESS: Springfield, Mo.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County: Greene — Registration District No. 318 — File No.

Township: Campbell — Primary Registration District No. 5439 — Registered No. 836

City ..... (No. ....., ... St. ..... Ward)

2. FULL NAME Tom Gowers

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*)
M	W	Wid

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14. INFORMANT .....
(Address)

15. FILED 12/1, 1928 OCHant [illegible]
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 1 1928

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..... to ....., 19..... that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Paralysis
due to apoplexy

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) ....., M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

S-40286