

9503-a  
MAY 20 1930

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

Do not use this space.

7503 a

1. PLACE OF DEATH

County Washington  
Township Lucas  
City          (No.         )

Registration District No. 887  
Primary Registration District No. 6182

File No.           
Registered No. 23  
St.          Ward         

2. FULL NAME William D. 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 Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 2-1873

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
54 - 8 - 8

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

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

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 Everett Sparks  
(Address) Potosi, Mo.

15. FILED 4/18 1930 Joe L. Thurman  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 10 1930

17. I HEREBY CERTIFY, That I attended deceased from Feb 4 1930 to Feb 10 1930 that I last saw          alive on Feb 8 1930 and that death occurred, on the date stated above, at          m.

THE CAUSE OF DEATH WAS AS FOLLOWS:  
Sabaz Pneumonia

100 (duration) yrs. mos. 10 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         

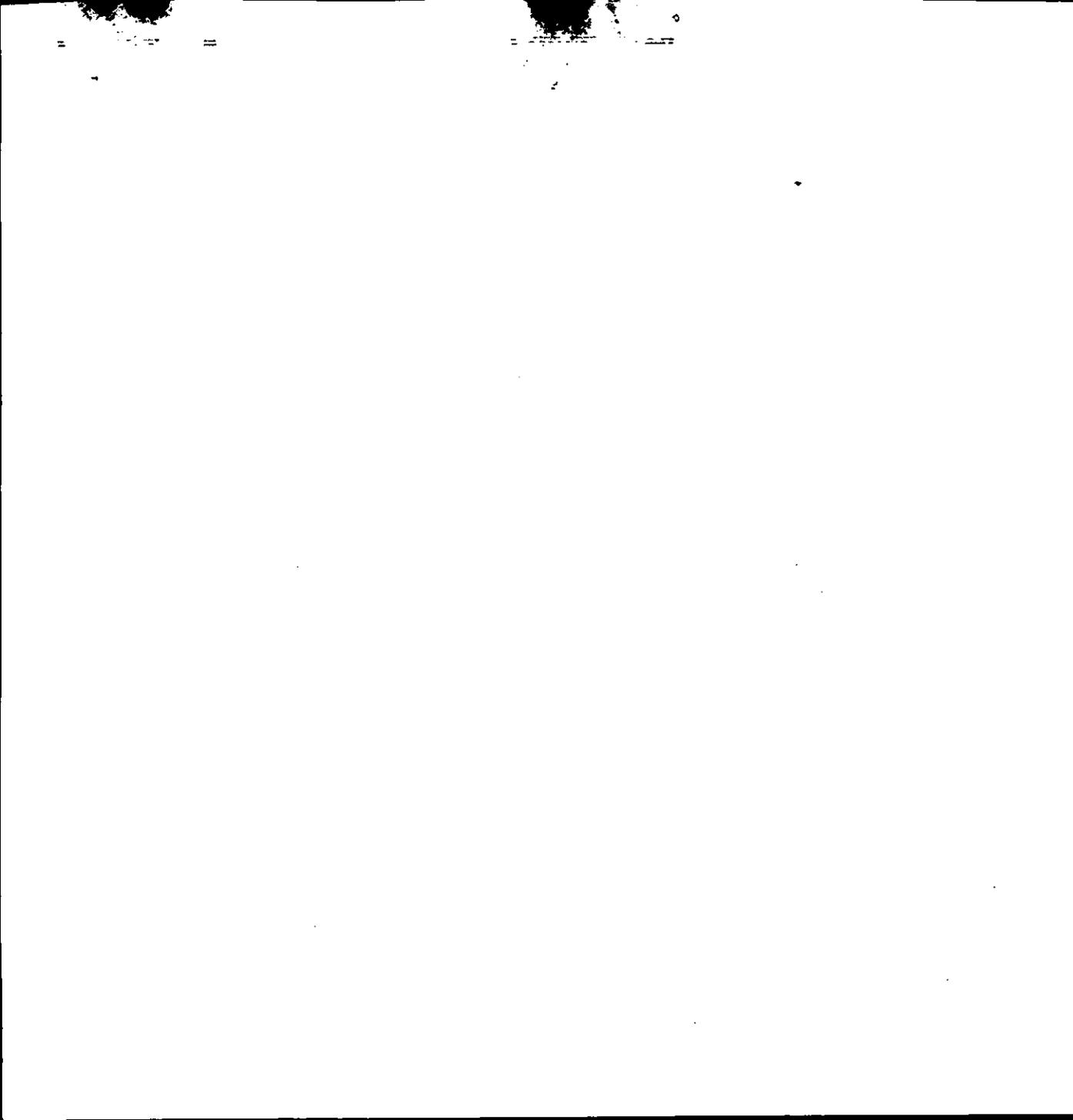
WAS THERE AN AUTOPSY?         

WHAT TEST CONFIRMED DIAGNOSIS  
(Signed) Sturwell, M. D.  
4/4 1930 (Address) Potosi

\*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 Old miss DATE OF BURIAL 7/11 1930

20. UNDERTAKER Sparks and ADDRESS Potosi



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

ALL INFORMATION REQUESTED  
HEREIN MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**PLACE OF DEATH.**

County Washington  
Township Union  
City (No. ....) .....

Registration District No. 887  
Primary Registration District No. 6182

File No. ....  
Registered No. 25  
St. .... Ward

**2. FULL NAME**

William D. Govers

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 6-2-1873

7. AGE YEARS MONTHS DAYS  
5-6 X 8 | 8  
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)

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 6-10-30 Jos. L. Plummer REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 10 19 30

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

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

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

UNTIL THEY ARE COMPLETE AS PREC.

REGISTRARS SHALL NOT RECEIVE A FEE

**SUPPLEMENTARY**

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