

NOV 22 1930

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

32607

1. PLACE OF DEATH

County Greene  
Township Springfield  
City Springfield (No. 290)

Registration District No. 318

Primary Registration District No. St. Johns Hospital

File No. \_\_\_\_\_  
Registered No. 764 St. \_\_\_\_\_ Ward)

2. FULL NAME

(a) Residence. No. 2406 East Ave St. R Ward 1  
(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 Unknown

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 22 - 1867

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
67 ~~79~~ 7 17

8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. Retired Car Carpenter (duration) yrs. mos. ds. (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) Jacksonville, Ind. Ill.

10. NAME OF FATHER John Gowers

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT (Address) Ray S. Gowers Springfield, Mo.

15. FILED 10-16-30 For Sharp REGISTRAR

MEDICAL CERTIFICATE OF DEATH

15. DATE OF DEATH (MONTH, DAY AND YEAR) 10-9-30

17. I HEREBY CERTIFY, That I attended deceased from 9-14, 1930 to 10-9, 1930 that I last saw him alive on 10-9, 1930 and that death occurred, on the date stated above, at 9:15 p.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Ch Myocardita  
Senility  
CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED (CITY OR TOWN) (STATE OR COUNTRY) NOT AT PLACE OF DEATH

19. DID AN OPERATION PRECEDE DEATH? No DATE OF \_\_\_\_\_ WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Physical Exam (Signed) L. M. Cregney M. D.

10/10, 1930 (Address) 923 N. Main 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 DATE OF BURIAL Green Lawn Cemetery Oct 11 1930

20. UNDERTAKER (Address) W. Klingner & Co. Springfield, Mo.

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.

