

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

Do not use this space.  
*J. O. Gabel*  
36960-B  
File No. \_\_\_\_\_  
Registered No. 9  
St. \_\_\_\_\_ Ward \_\_\_\_\_

201937

**PLACE OF DEATH**

County *Reynolds*  
Township *Yettle Prairie*  
City \_\_\_\_\_

Registration District No. *601*  
Primary Registration District No. *0862*

**2. FULL NAME**

*Joe M. Gower*

(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)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *3-10-1924*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
*6 8 11*

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) *Quincyville Ind*  
(STATE OR COUNTRY)

10. NAME OF FATHER *P. H. M. Gower*

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

12. MAIDEN NAME OF MOTHER *Ruth Bernice Gower*

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

14. INFORMANT *P. H. M. Gower*  
(Address) *Caruthersville Mo*

15. FILED *Feb 10 1931* *Ada Martin* REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *11-21 1930*

17. I HEREBY CERTIFY, That I attended deceased from *11-21-30* to *11-21-30*, 19*30* that I last saw him alive on *11-21-30*, 19*30*, and that death occurred, on the date stated above, at *3 A.*

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

*diphtheria*

*10* (duration) yrs. mos. *5* ds.

CONTRIBUTORY (SECONDARY) *10* (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) *Fred L. Oylor H. O.* M. D.  
*Caruthersville* (Address) *Nov 21, 1930*

\*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 *Maple cemetery* DATE OF BURIAL *11-21 1930*

20. UNDERTAKER *H. S. Smith* ADDRESS *Caruthersville Mo*

Exact statement of OCCUPATION is very important. CROSS OF DEATH in plain letters, so that it may be properly classified.

