

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

Do not use this space.

21642

JUL 17 1934

1. PLACE OF DEATH
 County St Clair Registration District No. 1037
 Township Jackson Primary Registration District No. 6012
 City Geniun, Mo (No.) St. Ward

2. FULL NAME
Sarah Gover
 (a) Residence, No. Ward.
 (Usual place of abode) Geniun, Mo (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

MEDICAL CERTIFICATE OF DEATH

3. SEX female **4. COLOR OR RACE** wh **5. SINGLE, MARRIED, WIDOWED, OR DIVORCED** (write the word) widowed

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 25 ✓
7. AGE YEARS 89 MONTHS 4 DAYS 21 If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as spinner, Sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Wife
10. Date deceased last worked at this occupation (month and year) **11. Total time (years) spent in this occupation**

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

13. NAME Tom Harris

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

15. MAIDEN NAME Sarah Hudspeth

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (ADDRESS) H. Gover
Geniun, Mo

18. BURIAL, CREMATION, OR REMOVAL
 PLACE Geniun DATE 6/17 1934

19. UNDERTAKER (ADDRESS) J. H. Murray
Geniun, Mo

20. FILED 9 1934 Mrs W F Hudson
Registrar.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 16 1934

22. I HEREBY CERTIFY That I attended deceased from , 1934, to June 16th, 1934
 I last saw her alive on about five months ago Death is said to have occurred on the date stated above, at 12:30 P m.

The principal cause of death and related causes of importance were as follows:
Chronic Heart Disease
Chronic Nephritis
Old age & arteriosclerosis
 Date of onset Unknown
 Other contributory causes of importance: 131

Name of operation None Date of
 What test confirmed diagnosis? Phys exam there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? Date of injury , 19
 Where did injury occur? (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.
 Manner of injury
 Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No
 If so, specify
 (Signed) J. H. Murray, M. D.
 (Address) Geniun, Mo

CAUSE OF DEATH... properly classified.

1974 FEB 24 10 11 AM '74

Handwritten notes and scribbles, mostly illegible due to low contrast and noise. Some faint words like "D", "W", "L", "S" are visible.

7

Handwritten mark or signature.

Handwritten mark or signature.

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: Jacob Gouwer
Who died at _____ on June 16 - 1934
Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____
Sex F Color or race W Single, married, widowed or divorced: _____

Date of birth Jan 25 Age: Years 59 Months 4 Days 21

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____
(b) Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____

Date deceased last worked at this occupation: Month _____ Year _____
Birthplace (State or country) _____
Birthplace of father (State or country) _____
Birthplace of mother (State or country) _____
Principal cause of death: _____

Other contributory causes of importance _____
Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____
If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19 _____
Where did injury occur? _____
(Specify city or town, county and State)

Specify whether injury occurred in industry ~~in home~~ ~~in public place~~
Manner of injury _____
Nature of injury _____
Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
Name of physician _____
Address of physician Mrs W T, Hudson
Signature of Registrar _____

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Reg. Dist. No. 1037

Primary Reg. Dist. No. 6012

Very truly yours,
E. J. Mc Gaugh m.d.
S.C.

Special Agent.

S-21642