

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

Do not use this space.

JAN 21 1936

42121

1. PLACE OF DEATH

County *St. Louis*

Registration District No. *802*

Township *Delmar*

Primary Registration District No. *4051*

City *Delmar* (No. *1*)

File No. _____

Registered No. _____

St. _____ Ward _____

2. FULL NAME

Elminda Josephine 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

MEDICAL CERTIFICATE OF DEATH

3. SEX

Female

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

wid

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Dec 25 1935*

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

None Gower

17. I HEREBY CERTIFY, That I attended deceased from *Dec 24 1935* to *Dec 25 1935* that I last saw him alive on *Dec 24 1935*, and that death occurred, on the date stated above, at *7:00 p.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Influenza

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

Aug 2-1855

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<i>80</i>	<i>7</i>	<i>17</i>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

CONTRIBUTORY (SECONDARY)

acc (duration) yrs. mos. ds.

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

10. NAME OF FATHER

Samuel Gower

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

St. Louis Mo

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Don't know

14. INFORMANT

(Address)

Anna G. Gower

15. FILED

1935

J. B. Bridges
REGISTRAR

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

at home

DID AN OPERATION PRECEDE DEATH? DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) *J. B. Bridges*, M. D.

, 19 *1935* (Address) *Delmar 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

Crawder cem

12-27 1935

20. UNDERTAKER

ADDRESS

Ray & Moore

Delmar Mo

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

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