

OCT 19 1937

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

Do not use this space.

34107

1. PLACE OF DEATH

County *Wray*
Township *J. Wood*
City *Prior* (No. *9*)

Registration District No. *276*
Primary Registration District No. *5389*

File No. *3*
Registered No. *3*
St. _____ Ward _____

2. FULL NAME

Hester McGowan

(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 *Female* 4. COLOR OF RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *widow*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *(date unknown) 1862*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
9 75 7

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) *unknown*
(STATE OR COUNTRY)

10. NAME OF FATHER *David Caldwell*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 *Mrs Ada Sloan*
(Address) *Prior Mo*

15. FILED *Sept 22 1937* *Tribble Sims*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *August 24 1937*

17. I HEREBY CERTIFY, That I attended deceased from *July 27*, 1937, to *August 24*, 1937, that I last saw her alive on *Aug 24*, 1937, and that death occurred, on the date stated above, at *12:30* a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

complication Bitten Disease caused by bite of dog named Sam on palmar surface left
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY)

(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH *49*DID AN OPERATION PRECEDE DEATH? *no* DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) *Dr. J. Osborn* M. D., 19 (Address) *Wyanter - 1*

*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

Stilwell cemetery

DATE OF BURIAL

Aug 25 1937

20. UNDERTAKER

Sam Stilwell

ADDRESS

55c

Handwritten text, possibly a signature or name, appearing upside down.

27

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

34109
Do not use this space.

1. PLACE OF DEATH

(a) County: Douglas Registration District No. 276
(b) Township: Wadd Primary Registration District No. 5389
(c) City: _____ (d) Street No. _____ Registered No. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Hester McSowan

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>7</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>wid</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)		
7. AGE	YEARS <u>25</u>	MONTHS <u>7</u>
	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.	
	9. Industry or business in which work was done, as saw mill, bank, etc.	
	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)		
FATHER	13. NAME	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)	
MOTHER	15. MAIDEN NAME	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)	
17. INFORMANT (ADDRESS)		
18. BURIAL, CREMATION, OR REMOVAL		
PLACE	DATE	19
19. FUNERAL DIRECTOR (ADDRESS)		
20. FILED _____ 19 _____		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 24 1939

22. I HEREBY CERTIFY, That I attended deceased from _____ 19____ to _____ 19____

I last saw h. _____ alive on _____, 19____. Death is said

to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Complications - Bright disease caused by urine retention and tumor on Fallopian tube left. My first in site of

Other contributory causes of importance:
This tumor was a bond 5 years ago then the size of a Turkey egg and discharged

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

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? _____

If so, specify _____

(Signed) J. A. Osborn M. D.

(Address) Sanzant Mo

Local Registrar

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENTARY

S-34107