

FILED OCT 18 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

File No. **32107**
Registrar's No. **11**

Registration District No. **327**

Primary Registration District No. **5457**

1. PLACE OF DEATH:
(a) County Grundy Myers Twp.
(b) City or town _____
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community Lepetonia _____ (Specify whether)
years, months or days

3. (a) PRINT FULL NAME JAMES THOMAS M^cGOYAN
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex male 5. Color or race Wh
6. (a) Single, widowed, married, divorced wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive dead years
7. Birth date of deceased March 18 - 1856
(Month) (Day) (Year)

8. AGE:
Years Months Days If less than one day
84 4 16 _____ hr. _____ min.

9. Birthplace Andrain Mo _____
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer _____

11. Industry or business Farming _____

12. Name Alexander M^cGowan _____

18. Birthplace Mo _____
(City, town, or county) (State or foreign country)

14. Maiden name Mary Calhoun _____

15. Birthplace Ky _____
(City, town, or county) (State or foreign country)

16. Informant H. M. Gowan _____

(b) Address Lebanon Mo _____

17. (a) Burial (b) Date thereof Aug 6 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Berry Cem. _____

18. (a) Signature of funeral director Johnson Son _____
(b) Address Lebanon Mo _____

19. (a) Aug 5 1940 (b) H. M. Gowan
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Grundy
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 3rd
year 1940 hour 9:45 minute P. M.

21. I hereby certify that I attended the deceased from Aug 3 1940
to Aug 3 1940
that I last saw him alive on Aug 1 1940
and that death occurred on the date and hour stated above.

Immediate cause of death
Cerebral thrombosis and hypertension
Due to Active Sclerosis

Other conditions (Include pregnancy within 3 months of death)
None

Major findings: Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
299 While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature H. M. Gowan (M. D. or other) _____
Address Lebanon Mo Date signed 7/5/40

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 11,

District File Number -----

Date Filed -----

NOV 11 1917

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed P. R. Payne Jr

Licensed Embalmer No. 3400

P. O. Address Galt

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.