

No. 2
-10-39
17-39
K21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Dr. Deizell

35342

State File No. _____

Registration District No. 318

Primary Registration District No. 2001

Registrar's No. 860

FILED NOV 12 1940

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Springfield
(c) Name of hospital or institution: Burge Hosp.
(d) Length of stay: In hospital or institution 2 days
In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene
(c) City or town Springfield
(d) Street No. Route # 9
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Harvey A. Gowers

3. (b) If veteran, name war no 8. (c) Social Security No. 500-10-3265

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mary Gowers 6. (c) Age of husband or wife if alive 29 years

7. Birth date of deceased February 26 1911
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>29</u>	<u>7</u>	<u>22</u>	hr. _____ min.

9. Birthplace Turner Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business _____

12. Name Walter Gowers

13. Birthplace Turner Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Clara Hildebrand

15. Birthplace Turner Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mary Gowers

(b) Address Turner, Missouri

17. (a) Burial (b) Date thereof Oct. 22 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Eastlawn

18. (a) Signature of funeral director H. H. Lohmeyer

(b) Address Springfield, Mo.

19. (a) 10-22-40 (b) W. E. Handley MD
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 18
year 1940 hour 8 minute 45 p. M.

21. I hereby certify that I attended the deceased from Oct 7, 1940, to Oct 18, 1940
that I last saw him alive on Oct 18, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death General Peritonitis
Due to ruptured appendix

Other conditions 17-1
(Include pregnancy within 3 months of death)

Major findings: Appendicitis
Of operations Appendectomy
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? Yes

23. Signature W. A. Schell (M. D. or other) _____
Address Springfield, Mo. Date, signed Oct 20/40

28. _____ (Licensed Embalmer's Statement on Reverse Side)

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

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

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.....

L. Dolin Gorman

Licensed Embalmer No. *3177*

P. O. Address *Springfield, W.*

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.

L.