

FILED OCT 3 1950

STANDARD CERTIFICATE OF DEATH

State File No. ....

No. 300  
10.48

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 170 PRIMARY REG. DIST. NO. 4264 Registrar's No. 345

530  
1  
WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Laclede</u>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Laclede</u> |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Conway</u> |  | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Conway</u> <u>153</u>                                      |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Conway</u>                                      |  | d. STREET ADDRESS (If rural, give location) _____  |  |

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 3. NAME OF DECEASED<br>(Type or Print) a. (First) <u>ADA</u> b. (Middle) <u>JANE</u> c. (Last) <u>GOWER</u> |  |  | 4. DATE OF DEATH (Month) (Day) (Year) <u>9-18-1950</u> |  |  |
|---|--|--|--|--|--|

|   |                               |   |                                   |   |   |   |
|---|-------------------------------|---|-----------------------------------|---|---|---|
| 5. SEX <u>Female</u>  | 6. COLOR OR RACE <u>white</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u> | 8. DATE OF BIRTH <u>2-15-1885</u> | 9. AGE (In years last birthday) <u>65</u>                 | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HRS. Hours _____ Min. _____ |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housekeeper</u> |                               | 10b. KIND OF BUSINESS OR INDUSTRY _____                               |                                   | 11. BIRTHPLACE (State or foreign country) <u>Missouri</u> |   | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 13a. FATHER'S NAME <u>Thomas Morland</u> |  | 13b. MOTHER'S MAIDEN NAME <u>Lebbie</u> |  | 14. NAME OF HUSBAND OR WIFE <u>Will GOWER</u> |  |
|--|--|---|--|---|--|

|   |                               |   |  |
|---|-------------------------------|---|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | 16. SOCIAL SECURITY NO. _____ | 17. INFORMANT'S SIGNATURE OR NAME <u>Will Gower</u> ADDRESS <u>Conway</u> |  |
|---|-------------------------------|---|--|

|  |  |   |  |                                  |  |
|--|--|---|--|----------------------------------|--|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)  |  | MEDICAL CERTIFICATION   |  | INTERVAL BETWEEN ONSET AND DEATH |  |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____   |  | DUE TO (b) <u>drowning in well.</u>   |  | _____                            |  |
| ANTECEDENT CAUSES  |  | DUE TO (c) _____  |  | _____                            |  |
| *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. |  | II. OTHER SIGNIFICANT CONDITIONS  |  | _____                            |  |
|  |  | Conditions contributing to the death but not related to the disease or condition causing death. |  | _____                            |  |

|                              |  |  |
|------------------------------|--|--|
| 19a. DATE OF OPERATION _____ | 19b. MAJOR FINDINGS OF OPERATION _____ | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|------------------------------|--|--|

|   |   |   |
|---|---|---|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Suicide</u> | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>home</u>              | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Conway Laclede MO.</u> |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____   | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | 21f. HOW DID INJURY OCCUR _____   |

22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at 6:45 p. m., from the causes and on the date stated above.

|  |                                 |                                      |
|--|---------------------------------|--------------------------------------|
| 23a. SIGNATURE <u>Richard L. Palmer</u> (Degree or title) <u>3</u> | 23b. ADDRESS <u>Libonoi MO.</u> | 23c. DATE SIGNED <u>Sep. 22 1950</u> |
|--|---------------------------------|--------------------------------------|

|   |                            |   |   |
|---|----------------------------|---|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 24b. DATE <u>9-22-1950</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Therape</u> | 24d. LOCATION (City, town, or county) (State) <u>Dallas Co Mo</u> |
|---|----------------------------|---|---|

|   |  |     |   |
|---|--|-----|---|
| DATE REC'D BY LOCAL REG. <u>9-23-1950</u> | REGISTRAR'S SIGNATURE <u>Hella L. Mayo</u> | 424 | 25. FUNERAL DIRECTOR'S SIGNATURE <u>R B Conner</u> ADDRESS <u>Raymo, Mo</u> |
|---|--|-----|---|

Received ----- SEP 30 1950  
LaSalle County Health Unit  
File No. .... 9-50-147  
Date Filed ..... OCT 1950

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 -----

working under my personal supervision.

Student Embalmer No. ....

Signed *George J. [Signature]*

Signed .....  
Student Embalmer

Licensed Embalmer No. *2508*

P. O. Address *Buffalo, Mo*

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, fact should be so stated above.