

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PLACE OF DEATH		MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH	
County	<u>Gasconade</u>	Registration District No.	<u>307</u>
Township	<u>Clay</u>	File No.	<u>38933</u>
Village		Primary Registration District No.	<u>6731</u>
City		Registered No.	
FULL NAME		[If death occurred in a hospital or institution, give its NAME instead of street and number]	
<u>Harold A. Gawer</u>			

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Married</u>	DATE OF DEATH <u>Dec. 16</u> (Month) (Day) (Year) <u>1917</u>	
DATE OF BIRTH <u>June 3rd</u> , <u>1834</u> (Month) (Day) (Year)			I HEREBY CERTIFY, that I attended deceased from <u>January</u> , 191 <u>7</u> , to <u>Dec. 16</u> , 191 <u>7</u> , that I last saw him alive on <u>Dec. 1st</u> , 191 <u>7</u> , and that death occurred, on the date stated above, at <u>9 a. m.</u>	
AGE <u>78</u> yrs. <u>6</u> mos. <u>13</u> ds.		IF LESS than 1 day, _____ hrs. or _____ min.?	The CAUSE OF DEATH* was as follows: <u>Recurrent stroke</u> <u>of paralysis</u> ✓ <u>11 P.M.</u> (Duration) _____ yrs. _____ mos. _____ ds.	
OCCUPATION (a) Trade, profession, or particular kind of work <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Retired</u>			Contributory <u>pre-disposition</u> (Duration) _____ yrs. _____ mos. _____ ds.	
BIRTHPLACE (City or town, State or foreign country) <u>Germany</u>			(Signed) <u>John D. Seb</u> M. D. <u>Dec 16</u> , 191 <u>7</u> (Address) <u>Blau, Mo.</u>	
PARENTS	NAME OF FATHER <u>John Gawer</u>		*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Germany</u>		LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS). At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.	
	MAIDEN NAME OF MOTHER <u>Katherine Stephan</u>		Where was disease contracted if not at place of death? Former or usual residence _____	
BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Germany</u>			PLACE OF BURIAL OR REMOVAL <u>Evangelical Cem.</u>	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE <u>H. S. Gawer</u> (Informant)			DATE OF BURIAL <u>Dec 18</u> , 191 <u>7</u>	
(ADDRESS) <u>Canaan, Mo. R.F.D.</u>			UNDERTAKER <u>J. W. Koenig</u>	
Filed <u>Dec 18</u> , 191 <u>7</u> <u>C. A. Dunge MD</u> REGISTRAR			ADDRESS <u>Blau, Mo.</u>	

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma*, *Sar-*

coma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)



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PLACE OF DEATH

County Gasconade
 Township Clay
 or
 Village _____
 or
 City _____ (NO. _____ St.; _____ Ward)

MISSOURI STATE BOARD OF HEALTH
 BUREAU OF VITAL STATISTICS
 REGISTRARS SHALL NOT RE-CEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

Registration District No. 302 File No. _____
 Primary Registration District No. 6231 Registered No. _____

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Karl A. Gower

PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OR RACE white SINGLE MARRIED married
 WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH June 3 1834
 (Month) (Day) (Year)

AGE 78 yrs. 6 mos. 13 ds. IF LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION (a) Trade, profession, or particular kind of work Farmer retired
 (b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE (City or town, State or foreign country) Germany

PARENTS
 NAME OF FATHER John Gower
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Germany
 MAIDEN NAME OF MOTHER Katherine Stephan
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Germany

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) G. F. Gower
 (ADDRESS) Canaan Mo. P.F.D.

Filed Dec 16 1912 Ed. Jung M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec. 16, 1912
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan. 1, 1911, to Dec. 16, 1912
 that I last saw him alive on Dec. 1, 1912
 and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:
recurrent stroke of paralysis
(Acute Ascending Paralysis)

Contributory (SECONDARY) predisposition
 (Duration) ___ yrs. ___ mos. ___ ds.
 (Signed) Geo. Deba M. D. X
Dec. 16, 1912 (Address) Bland, Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
 At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.
 Where was disease contracted if not at place of death? _____
 Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Evangelical Cew. DATE OF BURIAL Dec. 18, 1912
 UNDERTAKER F. W. Koenig ADDRESS Bland Mo.

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[Approved by U. S. Census and American Public Health
Association]

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