

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

Do not use this space.

16249

1. PLACE OF DEATH

County Dent
Township Lynn
City..... (No.....,St.Ward)

Registration District No. 266
Primary Registration District No. 5369

File No.....
Registered No. 38

2. FULL NAME George A. Mowery

(a) Residence, No.....St.,Ward. (If nonresident, give city or town and State)
(Usual place of abode)
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 male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Elizabeth Wofford

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 9 1867

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
67 1 8

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Farmer
9. Industry or business in which work was done, as silk mill, 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 Penn.

13. NAME Thomas Mowery

14. BIRTHPLACE (CITY OR TOWN)..... STATE OR COUNTRY Penn.

15. MAIDEN NAME Emma Eitzhold

16. BIRTHPLACE (CITY OR TOWN)..... STATE OR COUNTRY Penn.

17. INFORMANT Russell Mowery
(ADDRESS) Salem Mo

18. BURIAL, CREMATION, OR REMOVAL
PLACE Liner Com DATE 5/20/34 19

19. UNDERTAKER Carl Spencer
(ADDRESS) Salem Mo

20. FILED 5719 19 35 W. C. Ruedel, W. R.
Registrar.

4 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 17 1934 1934

22. I HEREBY CERTIFY, That I attended deceased from May 13th, 1934, to May 18th, 1934
I last saw him alive on May 15th, 1934. Death is said to have occurred on the date stated above, at 8:00 P.M.

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

Symphangitis with septemia following tick bite

Date of onset May 12, 1934

Other contributory causes of importance:

Cerebral Sclerosis

3 years

Name of operation..... Date of.....

What test confirmed diagnosis? Chloroform Was there an autopsy? No

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.....

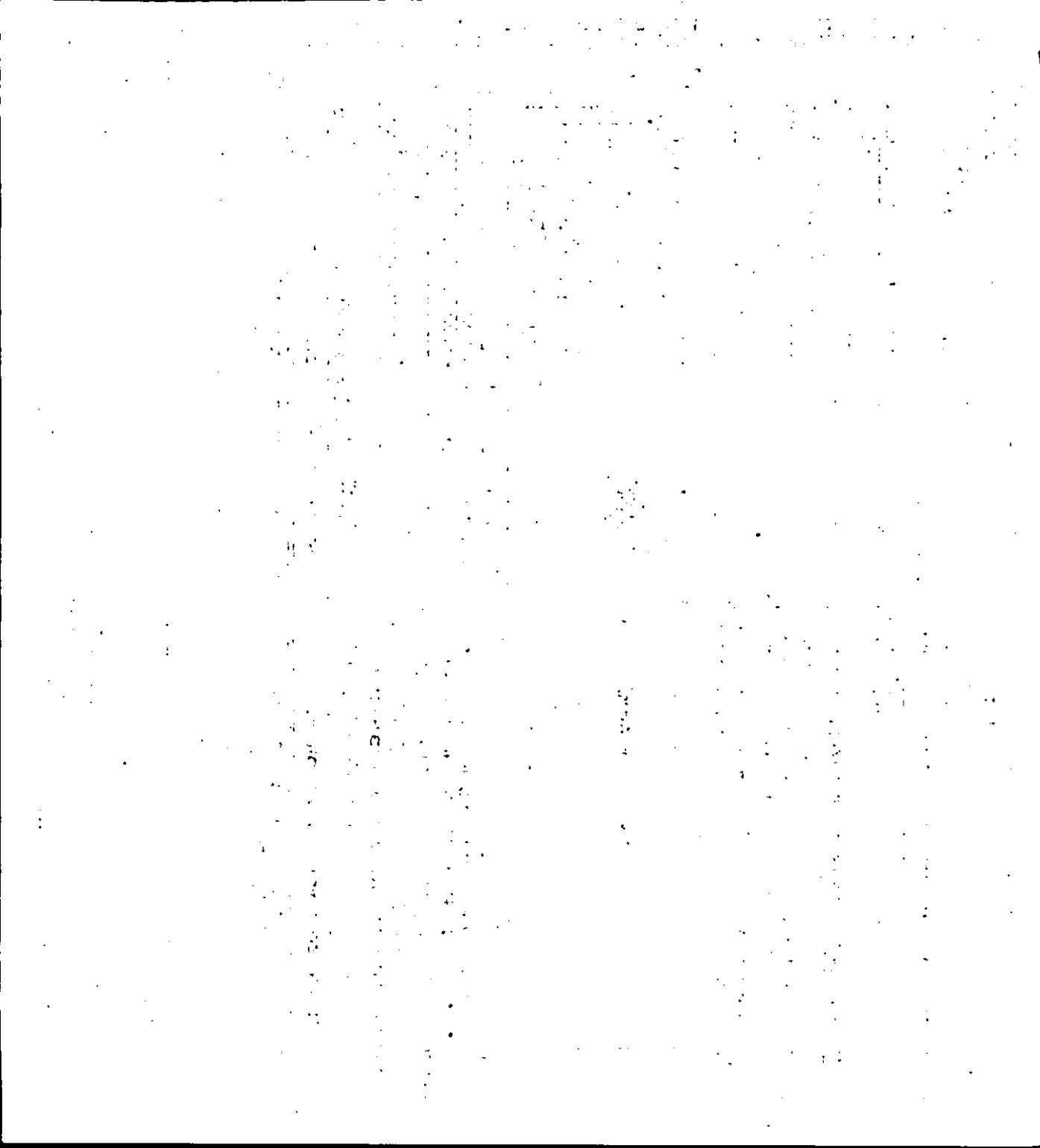
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify..... (Signed) A. E. Butler, M. D.

(Address) Salem, Missouri

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. JUN 21 1934



Dart

WASHINGTON

16249

38

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: George A. Mowery
Who died at _____ on May 17 - 1934
Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____
Sex m Color or race W Single, married, widowed or divorced: _____

Date of birth _____ Age: Years 67 Months 1 Days 8

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. (b) Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Date deceased last worked at this occupation: Months _____ Year _____
Birthplace (State or country) Tick bite fever
Birthplace of father (State or country) _____
Birthplace of mother (State or country) _____
Principal cause of death: _____

Other contributory causes of importance Cerebral hemorrhage
Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____
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 _____
Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
Name of physician _____
Address of physician _____

Signature of Registrar W.E. Rudd, M.D. Date filed 5/19/34

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Very truly yours,

E. T. McGaugh

State Registrar

Special Agent.

Reg. Dist. No. 266
Primary Reg. Dist. No. 5269

STANDARD FORM NO. 64

OFFICE OF THE SECRETARY OF DEFENSE

WASHINGTON, D. C. 20301

TO: THE SECRETARY OF DEFENSE
FROM: [Illegible]
SUBJECT: [Illegible]

[Illegible typed text]

[Illegible typed text]

[Illegible typed text]

5-16249

[Illegible typed text]

STANDARD FORM NO. 64 5-16249

[Illegible typed text]

UNITED STATES GOVERNMENT