

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **13316**

489

FILED MAY 4 1953

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u> <i>1117</i>	
c. LENGTH OF STAY (In this place) <u>60 years</u>		d. STREET ADDRESS (If rural, give location) <u>2917 Francis St.</u> <i>0.</i>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Missouri Methodist Hospital</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>William</u> b. (Middle) <u>C.</u> c. (Last) <u>Gow</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>April 24, 1953</u>		
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	
8. DATE OF BIRTH <u>May 15, 1866</u>			9. AGE (In years last birthday) <u>86</u>		IF UNDER 1 YEAR Months IF UNDER 6 MOS. Days Hours Mins.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>President</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>St. Joseph Guaranty Title Co.</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Holt, Missouri</u> <i>0</i>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					

13a. FATHER'S NAME <u>James Arthur Gow</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah Stone</u>		14. NAME OF HUSBAND OR WIFE <u>Nellie Holt Gow</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>493-18-9832</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Nellie Gow, 2917 Francis St., St. Joseph</u>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Occlusion</u>			INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs</u>
		ANTECEDENT CAUSES Ascribed conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Gen. arteriosclerosis</u>			<u>yes</u>
		DUE TO (c) _____			
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Hypostatic Pneumonia</u>			<u>12-16 hrs</u>

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>4201</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 4/22 ¹⁸⁵³, to 4-24, 1953, that I last saw the deceased alive on 4/24, 1953, and that death occurred at 3:00p. m., from the causes and on the date stated above.

23a. SIGNATURE <u>M. D. Grimes</u> (Degree or title) <u>M. D.</u>		23b. ADDRESS <u>St Joseph Mo</u>		23c. DATE SIGNED <u>4.25.53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>4/27/1953</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>	
				24d. LOCATION (City, town, or county) (State) <u>St. Joseph, Missouri</u>	

DATE REC'D BY LOCAL REG. <u>April 28, 1953</u>		REGISTRAR'S SIGNATURE <u>Kathleen M. Allison</u> <i>4850</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Hester Brown Funeral Home</u> <u>St Joseph, Mo</u>	
--	--	--	--	---	--

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10.48

117
0

MAY 13 1967

MAY 13 1967

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed George W. Carter

Licensed Embalmer No. 4814

P. O. Address _____

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.