MAY 29 1928

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

Do not use this space.

12206

1. PLACE OF DEATH

County Barry Registration District No. 37 File No.

Township ~~Flatt~~ Washburn Primary Registration District No. 8753 Registered No.

City near Washburn No. St. Ward)

2. FULL NAME Nannie Gower

(a) Residence. No. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

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: Fe	4. COLOR OR RACE: White	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widow	
5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF			
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 14 - 1924			
7. AGE — YEARS: 75	MONTHS: 4	DAYS: 21	If LESS than 1 day, ...hrs. or ......min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY) Barry Co Mo.

PARENTS

10. NAME OF FATHER James Durham

11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) U S A.

12. MAIDEN NAME OF MOTHER Marguarette Hubbard

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) unknown

14. INFORMANT Willie Gower
(Address) Washburn Mo

15. FILED 7/14 1928 J. E. Foley REGISTRAR

3

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4/11 1928

17. I HEREBY CERTIFY, That I attended deceased from Apr 5th, 1928, to Apr. 11th, 1928 that I last saw her alive on Apr 11th, 1928, and that death occurred, on the date stated above, at 4 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

153A Uremic Poisoning
132B
36 1540
(duration) Donot know yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Blood Poisoning & Elefontasis in limbs.
(duration) mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? Donot know
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) R. A. Stewart, M. D
, 19 (Address) Washburn, Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Roller Cemetery
DATE OF BURIAL 4/12 1928

20. UNDERTAKER Horine F & F
ADDRESS Cassville Mo

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.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
County Barry Registration District No. 37 File No.
Township Washburn Primary Registration District No. 3-0 5-3 Registered No.
City (No. , St. Ward)

2. FULL NAME Nannie Gowen

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 14 1853

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
75	7	27	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14. INFORMANT
(Address)

15. FILED , 19 J S Fowler
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4 - 11 1928

17. I HEREBY CERTIFY, That I attended deceased from , 19 to , 19 that I last saw h alive on , 19 , and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) , M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

Every question should be carefully answered. All information called for must 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.
REGISTRARS WILL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AND IN THE FORM PRESCRIBED BY LAW

S-12206