

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

Do not use this space.

29881

**1. PLACE OF DEATH**

County Jackson Registration District No. 399 File No. \_\_\_\_\_  
 Township Kaw Primary Registration District No. \_\_\_\_\_ Registered No. 3686  
 City Kansas City (No. K. C. General Hospital 1002) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME** Mrs. Sue Barlow

(a) Residence. No. 3928 College St. 16 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 16, 1891.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
39 5 20

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work At home  
 (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) Missouri

10. NAME OF FATHER M. F. Homan

11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) Missouri

12. MAIDEN NAME OF MOTHER Aetna Mylin

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) IOWA

14. INFORMANT E. A. Barlow  
 (Address) 3928 College, K. C. Mo

15. FILED 9/8 1930 M. M. Brown  
 REGISTRAR user

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-6-30

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 5:30 p.m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Suicide, Lysol  
poison  
1930

CONTRIBUTORY (SECONDARY) 166

18. WHERE WAS DISEASE CONTRACTED \_\_\_\_\_

IF NOT AT PLACE OF DEATH \_\_\_\_\_

19. DID AN OPERATION PRECEDE DEATH? No DATE OF \_\_\_\_\_

20. WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? Autopsy

(Signed) Stanley M. Hayes  
9/6, 1930 (Address) Physician

\*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 Smithton, Mo. DATE OF BURIAL Sept. 9 19 30

20. UNDERTAKER R. V. Lindsey & Sons, Inc ADDRESS Kans City 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.

