

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

3400  
Do not use this space.

2  
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**1. PLACE OF DEATH**

(a) County Madison Registration District No. 538  
 (b) Township Swedes Mill Primary Registration District No. 5-726 Registered No. 6  
 (c) City ..... (d) Street No. .... St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

**2. PRINT FULL NAME**

Rosabee Barber 616  
 (a) Residence, No. .... St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

**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 Sam S. Barber  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar. 29-1889  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
48 9 20  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife  
 9. Industry or business in which work was done, as saw mill, bank, etc. ....  
 10. Date deceased last worked at this occupation (month and year) ..... 11. Total time (years) spent in this occupation .....

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 17 1938  
 22. I HEREBY CERTIFY, That I attended deceased from Oct 27 1937 to Jan 17 1938  
 I last saw her alive on Jan 13 1938 Death is said to have occurred on the date stated above, at 6:15 P.M.  
 The principal cause of death and related causes of importance were as follows:

Malaria 28  
 Date of onset 1-3-38

Other contributory causes of importance: Infected Gall Bladder

Name of operation None Date of .....  
 What test confirmed diagnosis? ..... Was there an autopsy?

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?  
 If so, specify None  
 (Signed) S. C. Blaughton M. D.  
 (Address) Fredericktown

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Craighead Ark  
 FATHER 13. NAME Simpson Willmar  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown  
 MOTHER 15. MAIDEN NAME Sally Sigler  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown  
 17. INFORMANT S. S. Barber (ADDRESS) Cold water mo.  
 18. BURIAL, CREMATION, OR REMOVAL PLACE Antioch Cem. DATE Jan 18 1938  
 19. FUNERAL DIRECTOR None (ADDRESS) .....

20. FILED Jan 19 1938 S. C. Blaughton (Address) Fredericktown  
 Local Registrar  
 (Licensed Embalmer's Statement on Reverse Side)

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.

RECORDED

FEB 28 1938

BUREAU OF VITAL STATISTICS  
STATE BOARD OF HEALTH

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**STATEMENT BY LICENSED EMBALMER**

I, ....., Licensed Embalmer No.....

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

..... L. E. ....

No..... or by.....; Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

**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.)**