

DEC 16 1938

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

Do not use this space.

39593

1. PLACE OF DEATH

County Laclede Registration District No. 449
Township _____ Primary Registration District No. 4267
City Barlow Mo (No. Wallace Hospital)
St. _____ Ward _____

2. FULL NAME

David Barlow
(a) Residence, No. Crocker Mo 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. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 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 Wife - Isabelle Barlow

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug - 29 - 1893

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
45 2 5

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) Storia - Mo

13. NAME James Barlow

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

15. MAIDEN NAME Margaret Scates

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Camden - Mo

17. INFORMANT (ADDRESS) John Barlow - Barlow - Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Spring cemetery DATE _____ 19____

19. UNDERTAKER (ADDRESS) Woods & Son Crocker - Mo

20. FILED 11-26-38 J. A. McGraw Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 24, 1938

22. I HEREBY CERTIFY, That I attended deceased from Nov - 16, 1938, to Nov 24, 1938
Last saw him alive on Nov 23, 1938. Death is said to have occurred on the date stated above, at 1:30 a.m.
The principal cause of death and related causes of importance were as follows:

Myocardial infarction with cerebral hemorrhage

Date of onset

Other contributory causes of importance:

SSA!

Name of operation _____ Date of _____
What test confirmed diagnosis? Physical findings 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 _____
(Signed) W. H. Thompson, M. D.

(Address) 404 Wallace 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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

I X 9314

RECEIVED
District Health Officer No. 7,
District File Number 7-38-566
Date Filed 12-12-38

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

39593
Do not use this space.

1. PLACE OF DEATH

(a) County Laclede Registration District No. 449
 (b) Township Lepannon Primary Registration District No. 4267 Registered No.
 (c) City Lepannon (d) Street No.
 (If death occurred in Hospital or Institution, write its name instead of street and number) St.
 (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 David Barlow

(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 m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) un

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
45 2 5

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 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

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

FATHER
 13. NAME

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

MOTHER
 15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE Nov. 25, 1938

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 1-17-39 Ja. M. Couch Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 24, 1938

22. I HEREBY CERTIFY That I attended deceased from

I last saw him alive on 19..... Death is said to have occurred on the date stated above, at m.

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

Date of onset

Other contributory causes of importance:

Name of operation 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

(Signed) P. Thompson, M. D.

(Address) Lepannon

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENTARY

