

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

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

28509  
Do not use this space.

SEP 13 1939

1. PLACE OF DEATH *Barlow*

(a) County *Barlow* Registration District No. *43*

(b) Township *Barlow City* Primary Registration District No. *5065* Registered No. *4*

(c) City *Barlow* (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. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME *Katherine E McWilliam*

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

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 *Frank M McWilliam*

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
*81* *45* *10*

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. *Home Mfr.*

10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation *60*

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Northbrook Barlow*

13. NAME *General A Sieb* S

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

15. MAIDEN NAME *Melinda Sieb*

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

17. INFORMANT (ADDRESS) *Maria McWilliam*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Barlow City* DATE *Aug 19 1939*

19. FUNERAL DIRECTOR (ADDRESS) *G. B. Beers, 214 S. 1st St. Barlow, Mo.*

20. FILED *Sept 8, 1939 W.P. Beck* Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Aug 27 1939*

22. I HEREBY CERTIFY, That I attended deceased from *June 1 1928* to *Aug 26 1939*

I last saw her alive on *Aug 19 1939*. Death is said to have occurred on the date stated above, at *3 a.m.*

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

*Heart block*

Other contributory causes of importance: *Old age*

Name of operation *None* Date of \_\_\_\_\_

What test confirmed diagnosis? *Sublethal irregular heart*

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? *0* Date of injury *0*, 19*0*

Where did injury occur? *0* (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury *0*

Nature of injury *0*

24. Was disease or injury in any way related to occupation of deceased? *No*

If so, specify \_\_\_\_\_ (Signed) *J. G. Eddleman*, M. D.

*113* (Address) *Barlow Mo.*

STATEMENT BY LICENSED EMBALMER

I, Carroll T Beamy Licensed Embalmer No. 2385

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

L. E.

No. \_\_\_\_\_ or by \_\_\_\_\_, Registered Apprentice No. 217  
working under my personal supervision.

Signed Carroll T Beamy  
Licensed Embalmer No. 2385

**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.)**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

28509.

Do not use this space.

1. PLACE OF DEATH  
 (a) County Barton Registration District No. 43  
 (b) Township Barton City Primary Registration District No. 5065 Registered No. ....  
 (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 Katherine E. Mc Williams  
 (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

MEDICAL CERTIFICATE OF DEATH

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED M  
 (write the word)

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. or min.  
81 8 10

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. 4-20-1858

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

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 9-8, 1939 W. P. Peck Local Registrar.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-27, 1939

22. I HEREBY CERTIFY, That I attended deceased from ..... to ..... 19.....  
 I last saw h..... 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) A. G. Eddleman, M. D.  
 (Address) Liberal mo

N. B.—Every item of information should be carefully supplied. Accuracy is essential. All statements EXACTLY AS STATED. Statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified. REGISTRARS SHALL NOT RECEIVE A FEE OR CERTIFICA & UN - THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENTARY

