DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
AUG 16 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 25546

Registration District No. 479 Primary Registration District No. 4267 Registrar's No.

1. PLACE OF DEATH:
(a) County Laclede
(b) City or town Lebanon (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Wallace
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 32 Days (Specify whether
In this community years, months or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Miller
(c) City or town Rural (If outside city or town limits, write "RURAL")
(d) Street No. Iberia Mo. R# 1 (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME JESSIE BARLOW
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Jan (Month) 28 (Day) 1875 (Year)

8. AGE: Years 65 Months 2 Days 25 If less than one day hr. min.

9. Birthplace Camden Co. (City, town, or county) Mo (State or foreign country)
10. Usual occupation Farmer
11. Industry or business
MOTHER FATHER
12. Name James T. Barlow
13. Birthplace Arkansas (City, town, or county) (State or foreign country)
14. Maiden name Martha Barlow
15. Birthplace unknown (City, town, or county) (State or foreign country)
16. (a) Informant's own signature Mrs. Chas Bond
(b) Address Iberia Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 24-1940 (Month) (Day) (Year)
(c) Place: burial or cremation Watkins Mo
18. (a) Signature of funeral director E. L. Bacon 1404
(b) Address Iberia Mo
19. (a) 4-30-40 (Date received local registrar) (b) J. A. McComb (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 23 year 1940 hour 1 minute 8 M.

21. I hereby certify that I attended the deceased from 4-14-1940 to 4-23-1940 that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Paralysis of Cerebral Hemorrhage — Duration 40

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations none

Of autopsy none

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature M. D.
Address Date signed

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very impor

RECEIVED
District Health Officer No. 7,
District File Number 5-40-822
Date Filed 8-10-40

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
Lavan Adams, Registered Apprentice No. 24
working under my personal supervision.

Signed O. L. Casey
Licensed Embalmer No. 2694
P. O. Address Ibera, Mo.

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.)

If this body is not embalmed, above space should be left blank.

No. 2B
-2-21-40
I X22659

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 25-5-46.

Registration District No. 449 Primary Registration District No. 4267 Registrar's No.

1. PLACE OF DEATH:
(a) County Laclede
(b) City or town (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

3. (a) PRINT FULL NAME Jessie Barlow

3. (b) If veteran, name war 3. (c) Social Security No.

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced D

6. (b) Name of husband or wife 6. (c) Age of husband, or wife, if alive years

7. Birth date of deceased Jan (Month) 2 (Day) 1875 (Year)

8. AGE: Years 65 Months 2 Days 25 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) 4-30-46 (Date received local registrar) (b) J. A. McCourtney (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 23
year 1946 hour minute M.

21. I hereby certify that I attended the deceased from , 19, to 19;
that I last saw h alive on 19;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature E. E. Claiborne, M. D. or other)
Address Camdenton Date signed

SUPPLEMENTARY