

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

29578

State File No. ....

FILED OCT 4 1949

BIRTH NO. _____		REG. DIST. NO. <u>384</u>		PRIMARY REG. DIST. NO. <u>4085</u>		Registrar's No. <u>11</u>	
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).			
a. COUNTY <u>Carroll</u>		b. CITY (If outside corporate limits, write RURAL and give township) <u>Hale</u>		a. STATE <u>Mo</u>		b. COUNTY <u>Carroll</u>	
c. LENGTH OF STAY (In this place) <u>26 yrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Hale</u>		d. STREET ADDRESS (If rural, give location) _____		17 <u>00</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION _____				d. STREET ADDRESS (If rural, give location) _____			
3. NAME OF DECEASED			4. DATE OF DEATH			5. SEX	
a. (First) <u>William</u>	b. (Middle) <u>Hamilton</u>	c. (Last) <u>Barlow</u>	(Month) <u>Sept.</u>	(Day) <u>22</u>	(Year) <u>1949</u>	Male	6. COLOR OR RACE <u>White</u>
(Type or Print)							
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH		9. AGE (In years)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
<u>married</u>		<u>April 18 - 1873</u>		<u>76</u>		<u>farmer</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>farmer</u>		<u>Barber Co Ohio</u>		<u>Ohio</u>		<u>U.S.</u>	
13a. FATHER'S NAME <u>David Barlow</u>		13b. MOTHER'S MAIDEN NAME <u>Maritta Manning</u>		14. NAME OF HUSBAND OR WIFE <u>Ada Thompson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME		18. ADDRESS	
				<u>Mrs. Audrey Talley</u>		<u>Hale</u>	
18. CAUSE OF DEATH		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
Enter only one cause per line for (a), (b), and (c)		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>				<u>7 days</u>	
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES				10 yrs	
		DUE TO (b) <u>hypertension</u>				3 yrs	
		DUE TO (c) <u>Diabetic Mellitus</u>				<u>June 15 49</u>	
		II. OTHER SIGNIFICANT CONDITIONS					
		Conditions contributing to the death but not related to the disease or condition causing death. <u>Cerebral Hemorrhage c</u>					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21d. TIME OF INJURY	
				<u>21a X</u>			
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>Sept. 15</u> , 19 <u>49</u> , to <u>Sept 22</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>Sept. 22</u> , 19 <u>49</u> , and that death occurred at _____ m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Joseph P. Conroy M.D.</u>				23b. ADDRESS <u>Chillicothe Mo</u>		23c. DATE SIGNED <u>Sept 29 49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Sept 28 - 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Hale Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>New Hale Mo</u>	
DATE REC'D BY LOCAL REG. <u>9-30-49</u>		REGISTRAR'S SIGNATURE <u>Mrs. Rex Henderson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Trout &amp; Slater</u>		ADDRESS <u>Hale Mo.</u>	

RECEIVED OCT 3  
District Health Officer No. 8,  
District File Number \_\_\_\_\_  
Date Filed 10-3-49

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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed Frank E. Slater

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. 937

P. O. Address Nob. Ind

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, fact should be so stated above.