

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 state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **38319**

Registration District No. **791**

Primary Registration District No. \_\_\_\_\_

Registrar's No. **10159**

1. PLACE OF DEATH: **1003**  
 (a) County \_\_\_\_\_ **2**  
 (b) City or town **St. Louis,**  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
**2300 a South 10th Street**  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution **NO**  
 (Specify whether \_\_\_\_\_)  
 In this community \_\_\_\_\_  
 years, months or days

2. USUAL RESIDENCE OF DECEASED:  
 (a) State **Missouri** (b) County **1**  
 (c) City or town **St. Louis** **23**  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. **2300 South 10th St.**  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME **MARY BARLOW 640**  
 3. (b) If veteran, name war **NO** 3. (c) Social Security No. **NONE**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**  
 6. (b) Name of husband or wife **John Barlow** 6. (c) Age of husband or wife if alive **DECEASED** years  
 7. Birth date of deceased **July 4 1853**  
 (Month) (Day) (Year)

8. AGE: Years **86** Months **4** Days **24** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation **at home**

11. Industry or business **none**

MOTHER FATHER { 12. Name **James Casey 5**  
 13. Birthplace **not known Ireland**  
 (City, town, or county) (State or foreign country)  
 14. Maiden name **Ann O'Neil**  
 15. Birthplace **not known Ireland**  
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Ma Williams**

(b) Address **2300 So. 10th St.**

17. (a) **burial** (b) Date thereof **11-30-39**  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary**

18. (a) Signature of funeral director **A. J. ... Co**

(b) Address **2707 North Grand Bl.**

19. (a) **NOV 29 1939** (b) \_\_\_\_\_  
 (Date received local registrar) (Registrar's name)

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month **Nov** day **28**  
 year **1939** hour **2** minute **30 a. M.**

21. I hereby certify that I attended the deceased from **June 18 1929** to **Nov 28 1939**;  
 that I last saw her alive on **Nov 28 1939**;  
 and that death occurred on the date and hour stated above.

Immediate cause of death **Arterio Vasculor Genal Disease**  
 Due to **Arterio Sclerosis**  
 Due to **Senility**  
 Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: **None**  
 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) **NO**  
 (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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature **[Signature]** (M. D. or other) \_\_\_\_\_  
 Address **2302 S. ...** Date signed **11/28/39**

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**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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed..... *Paul F. Knudsenberg* .....

Licensed Embalmer No..... *9631* .....

P. O. Address..... *2707 N. Grand* .....

**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.**