

THE DIVISION OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

**35657**

STATE FILE NUMBER

FILED NOV 14 1957

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5013

5. 300  
1-57

|   |  |   |   |
|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Jackson</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>                  |   |
| b. CITY OR TOWN <b>Kansas City</b><br>(If outside corporate limits, give TOWNSHIP only)   |  | c. CITY OR TOWN <b>Kansas City</b><br>(If outside, give location)   |   |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>2700 Belleview</b>   |  | Length of stay in lb <b>7 yrs.</b>  |   |
| 3. NAME OF DECEASED<br>(Type or print)  |  | 4. DATE OF DEATH  |   |
| First <b>AARON</b> Middle <b>LEMUEL</b> Last <b>BARLOW</b>  |  | Month <b>Oct.</b> Day <b>27</b> Year <b>1957</b>  |   |
| 5. SEX <b>Male</b>  | 6. COLOR OR RACE <b>White</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>Dec. 6, 1889</b>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Barber</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Barber Shop</b>  | 11. BIRTHPLACE (City and state or country) <b>Hiawatha, Kansas</b>                                    |
| 13a. FATHER'S NAME <b>Andrew Jackson Barlow</b>   |  | 13b. MOTHER'S MAIDEN NAME <b>Virginia</b>   | 14. NAME OF HUSBAND OR WIFE <b>Sadie Barlow</b>   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes Mexican Conflict</b>   |  | 16. SOCIAL SECURITY NO. <b>512-03-6039</b>  | 17. INFORMANT Address <b>Mrs. Sadie Barlow-2700 Belleview, K.C. Mo</b>                                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b><br>DUE TO (b) <b>Arteriosclerosis</b><br>DUE TO (c) _____<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |  |   | INTERVAL BETWEEN ONSET AND DEATH <b>331 X</b>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)   |  |   | 19. WAS AUTOPSY PERFORMED? <b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)  |   |
| 20c. TIME OF INJURY<br>Hour _____ Month, Day, Year _____<br>a.m. _____ p.m. _____   |  |   |   |
| 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION  | COUNTY STATE  |
| 21. I attended the deceased from _____, to _____ and last saw her/him alive on _____<br>Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.  |  |   |   |
| 22a. SIGNATURE <b>Geo. C. Kealhofer</b> (Degree or title) <b>3</b>  |  | 22b. ADDRESS <b>6627 Park St. S. Mo</b>   | 22c. DATE SIGNED <b>10-27-57</b>  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>  | 23b. DATE <b>Oct. 30, 1957</b>   | 23c. NAME OF CEMETERY OR CREMATORY <b>OLD HURON CEMETERY</b>  | 23d. LOCATION (City, town, or county) (State) <b>Hiawatha, Kansas</b>                                 |
| 24. FUNERAL DIRECTOR ADDRESS <b>QUIRK &amp; TOBIN-20 W. Linwood, K.C. Mo.</b>   |  | 25. DATE RECD. BY LOCAL REG. <b>10-29-57</b>  | 26. REGISTRAR'S SIGNATURE <b>Neva Marshall</b>  |

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Social, coroner, etc. must use only standard nomenclature in their 16. No symptoms will be listed. All diseases in Part I must be causally related.

Geo. C. Kealhofer



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.

Student ..... Signature of Student Embalmer

Signed *E. C. Gibson* .....

Licensed Embalmer No. *4137* .....

P. O. Address *K.C. 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting. If this body is not embalmed, fact should be so stated above.