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

PLACE OF DEATH

County St. Louis

Township Central

or Village ~~Normandy Heights~~

or City ____ (NO. ____ St.: ____ Ward)

Registration District No. 789 — File No. 36632

Primary Registration District No. 603 3 B — Registered No. 150

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Sarah Lucille (Barnicle) Barnicle

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	White	Single

DATE OF BIRTH July 10th, 1914 (Month) (Day) (Year)

AGE ____ yrs. 4 mos. 2 ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) ____

BIRTHPLACE (City or town, State or foreign country) Crawford Co. Mo. R 2 ?

PARENTS

NAME OF FATHER Thomas Barnicle

BIRTHPLACE OF FATHER (City or town, State or foreign country) Crawford Co Mo.

MAIDEN NAME OF MOTHER Amanda Bell

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Crawford Co. Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Andy Barnicle

(ADDRESS) Creve Coeur #37

Filed ____, 191__. ____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH November 12, 1914 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Oct. 11th, 1914, to Nov. 12, 1914, that I last saw h[illegible] alive on Nov 10, 1914, and that death occurred, on the date stated above, at 8:30 p.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis

25 3 1 (Intestinal)

(Duration) ____ yrs. 4 mos. ____ ds.

Contributory ____

0 (SECONDARY)

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) H. J. Coleman M. D.

Nov. 13. 1914 (Address) Pattonville Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death? ____

Former or usual residence ____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Creve Coeur	Nov. 14. 1914
UNDERTAKER	**ADDRESS**
A Bauman	Creve Coeur

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory. The* material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*) For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc. of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "*Asthenia*,""Anaemia" (merely symptomatic),"Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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

PLACE OF DEATH

County St Louis

Township Central

or

Village

or

City (NO. St.; Ward)

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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

Registration District No. 789

Primary Registration District No. 6033B

File No.

Registered No. 150

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME ~~Sarah~~ Lucille Bamiele

PERSONAL AND STATISTICAL PARTICULARS

SEX F

COLOR OR RACE W

SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) S

DATE OF BIRTH ~~Information Supplied~~ (Month) (Day) 1 (Year)

AGE ~~Information Supplied~~ yrs. mos. ds.

If LESS than 1 day, hrs. or min.

OCCUPATION
(a) Trade, profession, or particular kind of work ~~Information Supplied~~

(b) General nature of industry, business, or establishment in which employed (or employer) ~~Information Supplied~~

BIRTHPLACE (City or town, State or foreign country) ~~Information Supplied~~

PARENTS

NAME OF FATHER ~~Information Supplied~~

BIRTHPLACE OF FATHER (City or town, State or foreign country) ~~Information Supplied~~

MAIDEN NAME OF MOTHER ~~Information Supplied~~

BIRTHPLACE OF MOTHER (City or town, State or foreign country) ~~Information Supplied~~

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(ADDRESS)

Filed Jan 5, 1915 W. E. Harrel REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH ~~Nov~~ Dec 12 (Month) (Day) 191~~3~~4 (Year)

I HEREBY CERTIFY, that I attended deceased from ~~Nov~~ Dec 1914, to ~~Nov~~ Dec 1914, that I last saw h alive on ~~Nov~~ Dec 1914, and that death occurred, on the date stated above, at 8:30 m.

The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos. ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) M. D.

191 (Address)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL 191

UNDERTAKER

ADDRESS

SUPPLEMENTARY

Original file, date NOV 1914 19 All information called for must be written on this Supplementary Certificate.

Revised United States Standard Certificate of Death

[Approved by U. S. Consus and American Public Health Association]

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