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. 23625

AUG 11 1939

Registration District No. 791 1003

Primary Registration District No.

Registrar's No. 5898

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis, Mo. (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: City Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 48 days (Specify whether

In this community 17 yrs years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County ~~St. Louis~~

(c) City or town ~~Maplewood~~ St Louis (If outside city or town limits, write "RURAL") ~~NR~~

(d) Street No. 6910 Waldemar (If rural, give location) 4

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Earl Barnicle 652

3. (b) If veteran, name war No —

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 Sept (Month) 9 (Day) 1921 (Year)

8. AGE: Years 17 Months 9 Days 23 If less than one day hr. min.

9. Birthplace Keysville, Mo. (City, town, or county) (State or foreign country) 0

10. Usual occupation student 0

11. Industry or business 0

FATHER
12. Name John Barnicle
13. Birthplace Crawford County, Mo. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Viola
15. Birthplace Crawford County, Mo. (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. J. A. Barnicle

(b) Address 6910 Waldemar

17. (a) Wesconia (Burial, cremation, or removal) (b) Date thereof July 4, 1939 (Month) (Day) (Year)

(c) Place: burial or cremation Wesco, Mo.

18. (a) Signature of funeral director Alexander & Sons

(b) Address 6175 Delmar, Blvd

19. (a) JUL 3 1939 (Date received local registrar) (b) J. F. Budeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day July year 1939 hour 4:10 minute P. M.

21. I hereby certify that I attended the deceased from 5/16, 1939 to July 2, 1939 that I last saw him alive on July 2, 1939 and that death occurred on the date and hour stated above.

Immediate cause of death

Duration

Osteogenic Sarcoma

Due to Primary seat Humerus

Due to

Other conditions (Include pregnancy within 3 months of death) 53

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 [signature] (M. D. or other)

Address City Hospital Date signed

(Licensed Embalmer's Statement on Reverse Side)

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 J. Wm Dinkler

Licensed Embalmer No. 3653

P. O. Address St Louis, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

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