

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

28362  
Do not use this space.

1. PLACE OF DEATH *Wm SEP 19 1940*  
 (a) County *Crowford* Registration District No. *231*  
 (b) Township *Meramec* Primary Registration District No. *5314*  
 (c) City or \_\_\_\_\_ (d) Street No. \_\_\_\_\_ St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U.S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME *Lee A. Barnicle*  
 (a) Residence, No. *Meramec T.P. Rural* (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX *M* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Single*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Feb 15 1881*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
*59 3 3*

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as saw mill, bank, etc. *Farmer*  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Crowford Mo*

13. NAME *James Barnicle*  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Pa*

15. MAIDEN NAME *Amadia Hauswirth*  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Tenn*

17. INFORMANT (ADDRESS) *Walter Barnicle  
Steelville Mo*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Barnicle* DATE *7 19 - 19 40*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *J. J. Janas  
Steelville Mo*

20. FILED *8-6-* 19 *40* *Local Registrar*

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *May 18 - 19 40*

22. I HEREBY CERTIFY, That attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_.

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.  
 The principal cause of death and related causes of importance were as follows:  
*No physician in attendance  
Death sudden*

Other contributory causes of importance: \_\_\_\_\_

Name of operation: \_\_\_\_\_ Date of: \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased?  
 If so, specify \_\_\_\_\_  
 (Signed) *Ray M. Janas (Printer, M.D.)*  
 (Address) *Steelville Mo*

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.

RECEIVED

District Health Officer No. 5,

District File Number 840 865

Date Filed \_\_\_\_\_

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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.....

Licensed Embalmer No.....

P. O. Address.....

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.