

No. 300
10-48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **7224**

BIRTH NO. **FILED MAR 5 1954** REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **590** Registrar's No. **502**

Foot

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY St. Louis | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Wellston | | c. CITY OR TOWN Wellston 43011 | |
| c. LENGTH OF STAY (In this place) 20 yrs | | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION 6532 Easton Avenue | | e. STREET ADDRESS (If rural, give location) 6532 Easton Avenue | |

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| 3. NAME OF DECEASED (Type or Print) a. (First) Lena b. (Middle) Vadna c. (Last) Barnicle | | | 4. DATE OF DEATH (Month) (Day) (Year) Feb. 24, 1954 | | |
|--|--|--|--|--|--|

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|----------------------|--|-------------------------------|--|--|--|--------------------------------------|--|---|--|-----------------------|--|---------------------|--|----------------------|--|---------------------|--|
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced | | 8. DATE OF BIRTH May 27, 1899 | | 9. AGE (In years last birthday) 54 | | F UNDER 1 YEAR Months | | F UNDER 2 HRS. Days | | F UNDER 2 HRS. Hours | | F UNDER 2 HRS. Min. | |
|----------------------|--|-------------------------------|--|--|--|--------------------------------------|--|---|--|-----------------------|--|---------------------|--|----------------------|--|---------------------|--|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk | | | 10b. KIND OF BUSINESS OR INDUSTRY Grocer | | | 11. BIRTHPLACE (City and State or Foreign Country) Maryland Heights, Mo. | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
|--|--|--|---|--|--|---|--|--|--|--|--|

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| 13a. FATHER'S NAME Thomas Barnicle | | | 13b. MOTHER'S MAIDEN NAME Amanda Ball | | | 14. NAME OF HUSBAND OR WIFE XXXXX Divorced | | |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None | | 16. SOCIAL SECURITY NO. 191-26-2727 | | 17. INFORMANT'S SIGNATURE OR NAME Amanda Barnicle | | ADDRESS 3021-Calvert Av-Overland | |
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| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) | | MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of the hard palate of the mouth | | | | | | 18 mo. | |
| | | ANTECEDENT CAUSES | | | | | | | |
| | | Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. | | | | | | | |
| | | DUE TO (b) | | | | | | | |
| | | DUE TO (c) | | | | | | | |
| | | II. OTHER SIGNIFICANT CONDITIONS | | | | | | | |
| | | Conditions contributing to the death but not related to the disease or condition causing death. | | | | | | | |

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|------------------------------------|--|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION none | | 19b. MAJOR FINDINGS OF OPERATION 144x | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
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| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) no | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) no | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) | |
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|--|--|--|--|----------------------------|--|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | |
|--|--|--|--|----------------------------|--|

22. I hereby certify that I attended the deceased from **21 April, 1953**, to **24 Feb.**, 1954, that I last saw the deceased alive on **23 Feb.**, 1954, and that death occurred at **2:00 p.m.**, from the causes and on the date stated above.

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|---|--|---------------------------------------|--|------------------------------------|--|
| 23a. SIGNATURE (Degree or title) Luke A. Kruse, M.D. | | 23b. ADDRESS 1506 Woodmont Ave | | 23c. DATE SIGNED 26 Feb. 54 | |
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| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24b. DATE 2-27-1954 | | 24c. NAME OF CEMETERY OR CREMATORY Hiram Burial Park | | 24d. LOCATION (City, town, or county) (State) Creve Coeur, Mo. | |
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| DATE REC'D BY LOCAL REG. 2-26-54 | | REGISTRAR'S SIGNATURE Herbert R. Domba M.D. | | 25. FUNERAL DIRECTOR'S SIGNATURE Blumhardt Bros. Inc. | | ADDRESS 2504-Woodson Rd-Overland-11-Mo. | |
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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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *David C. Gibson*.....

Licensed Embalmer No. *345*.....

P. O. Address *Orlando*.....

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.