DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 38151

DEC 13 1939 791

Registration District No. 1003

Primary Registration District No.

Registrar's No. 9990

**1. PLACE OF DEATH:**

(a) County 1

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

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

(d) Length of stay: In hospital or institution 8 hours (Specify whether years, months or days)

In this community Since Birth

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County 1

(c) City or town St. Louis 9
(If outside city or town limits, write "RURAL")

(d) Street No. 5107a North Broadway
(If rural, give location)

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

3. (a) PRINT FULL NAME MAE A. OONK 5 2 4

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Bernard C. Oonk

6. (c) Age of husband or wife if alive 34 yrs years

7. Birth date of deceased May (Month) 1 (Day) 1904 (Year)

8. AGE: Years 35 | Months 6 | Days 21 | If less than one day ____ hr. ____ min.

9. Birthplace St. Louis (City, town, or county) Missouri (State or foreign country)

10. Usual occupation At Home

11. Industry or business

FATHER
12. Name John J. Quirk
13. Birthplace St. Louis (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name Annie Conners
15. Birthplace St. Louis (City, town, or county) Missouri (State or foreign country)

16. (a) Informant's own signature Bernard C. Oonk
(b) Address 5107a North Broadway

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/25/39 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Math. Hermann & Son
(b) Address 2161 East Fair Avenue

19. (a) NOV 22 1939 (Date received local registrar) (b) J. F. Burkhart (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Nov. day 22 year 1939 hour 2 minute 30 PM.

21. I hereby certify that I attended the deceased from May, 1939, to Nov 22, 1939 that I last saw her alive on Nov. 22, 1939 and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death: Obstetrical Shock | 6 hrs. |
| Due to: Inversion of Uterus | |
| Due to: Pregnancy | term |
| Other conditions (Include pregnancy within 3 months of death) | |

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 Dr. Fred J. Grove (M. D. or other) M D
Address 5738 W Florissant Date signed 11-22-39

(Licensed Embalmer's Statement on Reverse Side)

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

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.

REV. 5-17-39 1 X10311

## 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. 2967

P. O. Address St. Louis, 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 this body is not embalmed, above space should be left blank.**