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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

NOV 16 1940

Registration District No. 791

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 33796

Primary Registration District No. 1003

Registrar's No. 8493

1. PLACE OF DEATH:

(a) County

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

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

(d) Length of stay: In hospital or institution 21 days (Specify whether years, months or days)

In this community Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town St. Louis 2
(If outside city or town limits, write "RURAL")

0

(d) Street No. 4924 Bonita Ave.
(If rural, give location)

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

3. (a) PRINT FULL NAME Katherine Rooney

3. (b) If veteran, name war ----

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Michael

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

7. Birth date of deceased April (Month) 9, (Day) 1872 (Year)

8. AGE: Years 68 | Months 6 | Days 3 | If less than one day ___ hr. ___ min.

9. Birthplace St. Louis (City, town, or county) Missouri (State or foreign country) 0

10. Usual occupation Home 6

11. Industry or business 9

FATHER
12. Name Gerhardt Kuenemeyer
13. Birthplace Unknown (City, town, or county) Germany (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant X Mrs. A. G. Pollvogt
(b) Address 4556 Clarence Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/15/40 (Month) (Day) (Year)

(c) Place: burial or cremation New S.S. Peter & Paul

18. (a) Signature of funeral director Wacker-Helderle
(b) Address 2331 S. Broadway

19. (a) OCT 14 1940 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 12
year 1940 hour 3 minute 20 a.M.

21. I hereby certify that I attended the deceased from Aug 12, 1940, to October 12, 1940, that I last saw her alive on October 12th, 1940, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Sarcoma of left Scapula - left Humerus and Bones of Pelvis	2 mo.
Due to: Carcinoma of left Ovary	9 mo.
Due to:	
Other conditions: none (Include pregnancy within 3 months of death)	

Major findings:
Of operations: Carcinoma of Ovary left Dermoid Cyst Right
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) no
(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 Julius Chas Kotter (M. D. or other) M.D.
Address 2603 Cherokee St. Date signed Oct 12 40

(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 Frank J. Wyland

Licensed Embalmer No. 2645

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, fact should be so stated above.