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

Do not use this space.

38913

1. PLACE OF DEATH

County..... Registration District No. 791

Township..... Primary Registration District No. 1007

City St. Louis (No. St. Deaconess Hospital St. ..... Ward)

File No. ..... Registered No. 11387

2. FULL NAME Christian H. Oonk

(a) Residence. No. 4109 Kossuth St., 10 Ward.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Married.

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Helene Oonk

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 20. 1855

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	73	10	29	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) Shoe Merchant
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) St. Louis
(STATE OR COUNTRY) Mo.

PARENTS

10. NAME OF FATHER Christian Oonk
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Holland
12. MAIDEN NAME OF MOTHER Anna Hellinger
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Switzerland

14. INFORMANT Helene Oonk
(Address) 4109 Kossuth

15. FILED Nov 20 1929 Mike C. Stark
REGISTRAR

5 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 19 1929.

17. I HEREBY CERTIFY, That I attended deceased from Nov. 19, 1929, to Nov. 19, 1929 that I last saw h. alive on Nov. 19, 1929, and that death occurred, on the date stated above, at 5:40 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Dilatation of Heart 1 day
Chronic Myocarditis 3 yrs
Intestinal Obstruction due to Bowel Adhesions

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Double Inguinal Hernia

..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? yes DATE OF 11-19-29
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? clinical
(Signed) Cleveland J. Hurt M. D.
11-20, 1929 (Address) 305 Metropolitan Bldg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
St. John Cemetery	11/22 1929
20. UNDERTAKER	**ADDRESS**
Thos. A. Beiderwieden	1936 St. Louis

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.

WHITE PAPER, WITH UNFADING INK—THIS IS A PERMANENT RECORD

2-13-155