

S. No. 2
FORM-5-43
Rev. 5-17-39
I. X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

FILED NOV 23 1945 **STANDARD CERTIFICATE OF DEATH**

State File No. **35759**
Registrar's No. **9843**

Registration District No. **318** Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County St. Louis

(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. Johns Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 months
(Specify whether in this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

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

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

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME William Leo Quirk

3. (b) If veteran, name war World #1

3. (c) Social Security No. _____

4. Sex Male 0 5. Color or race White

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

6. (b) Name of husband or wife Victoria M. Quirk nee Dinkela

6. (c) Age of husband or wife if alive 45 years

7. Birth date of deceased June 29 1898
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Nov. day 12th
year 1945 hour 3:00 PM. minute _____ M.

21. I hereby certify that I attended the deceased from 11/6 to 11/12, 1945.

that I last saw him live on 11/12, 1945 and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>47</u>	<u>4</u>	<u>14</u>	hr. _____ min. _____

Immediate cause of death Carcinoma of medietinum type not known

Due to _____

Due to _____

Other conditions none
(Include pregnancy within 3 months of death)

Major findings: none

Of operations none

Of autopsy none

9. Birthplace Muncie Ind. /
(City, town, or county) (State or foreign country)

10. Usual occupation Deputy Sheriff

11. Industry or business _____

MOTHER FATHER { 12. Name William Quirk

13. Birthplace Unknown Ireland /
(City, town, or county) (State or foreign country) /

14. Maiden name Clara Belle Peckinpugh

15. Birthplace Unknown Indiana /
(City, town, or county) (State or foreign country) /

PHYSICIAN

Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs Victoria M. Quirk

(b) Address 4924 Terry Ave

17. (a) Burial (b) Date thereof 11/16/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Math Hermann & Son

(b) Address 2161 East Fair Ave

19. (a) NOV 14 1945 (b) J. Bredeck
(Date received local registrar) (Registrar's signature)

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? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature John Hammond (M. D. or other) M.D.

Address 634 N. Grand Date signed 11/13/45

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 William G. Burkholder
Licensed Embalmer No. 2110
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, fact should be so stated above.