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.

REC'D MAR 13 1939

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

791
1003

4531
Do not use this space.

1. PLACE OF DEATH

(a) County ..... Registration District No. 1003

(b) Township ..... Primary Registration District No. ..... Registered No. 1224

(c) City St. Louis, Missouri (d) Street No. City Sanitarium St.
(If death occurred in Hospital or Institution, write its name instead of street and number)

(e) Length of residence in city or town where death occurred 58 yrs. mos. 24 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 615 Joseph Frank Urban, Sr.

(a) Residence, No. 5054 Gresham St. 2
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF Elizabeth Zike Urban

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 1-12-1881

7. AGE: Years 58 | Months 0 | Days 24 | If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Machinist

9. Industry or business in which work was done, as saw mill, bank, etc. Machinsit

10. Date deceased last worked at this occupation (month and year) 1935

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis, Missouri

FATHER

13. NAME Joseph Urban

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown Bohemia

MOTHER

15. MAIDEN NAME Mary Cochaneck

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown Bohemia

17. INFORMANT (ADDRESS) John B. Varner, M.D. 5400 Arsenal St.

18. BURIAL, CREMATION, OR REMOVAL
PLACE S. Peter & Paul DATE 2/8/39 19

19. FUNERAL DIRECTOR (NAME) Wm. C. Moydell
(ADDRESS) 1926 Allen, Ave.

20. FILED FEB 7 1939 19 J. F. Bridick Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-5-39 19

22. I HEREBY CERTIFY, That I attended deceased from 7-1-38, 19..., to 2-5-1939, 19...
I last saw him alive on 11:00 A.M., 19 39 Death is said to have occurred on the date stated above, at ..... m.
The principal cause of death and related causes of importance were as follows:

Date of onset

Arteriosclerosis -generalized 5-2-1935x

Other contributory causes of importance:
Chronic Myocarditis with Secondary Anemia 6-38

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? NO

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19...
Where did injury occur? ..... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury .....
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....
(Signed) John B. Varner, M. D.
(Address) City Sam

(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 Benj. C. Duncan

Licensed Embalmer No. 7272

P. O. Address 1926 Allen Ave

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.