

No. 2
11-10-39
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I

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

13451

MAY 15 1940 791

State File No. _____

Registration District No. _____

Primary Registration District No. 1003

Registrar's No. 3653

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's Hosp.
(If not in hospital or institution, write street number or location)

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

In this community _____ 40 _____
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Kate Urban 6 15

3. (b) If veteran, name war _____ no

3. (c) Social Security No. _____ no

4. Sex Female

5. Color or race Wht.

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

6. (b) Name of husband or wife Alphonse Urban

6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased March 23 1893
(Month) (Day) (Year)

8. AGE: Years 47 Months _____ Days 18 If less than one day _____ hr. _____ min.

9. Birthplace Lithuanian
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____ 7

12. Name John Szydowski

13. Birthplace Lithuania
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

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

16. (a) Informant Alphonse Urban

(b) Address 4473 Gannett

17. (a) Burial (b) Date thereof April 24 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director W. B. Moyell

(b) Address 1926 Allen Ave.

19. (a) APR 23 1940 (b) _____
(Date received local registrar) (Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

(c) City or town St. Louis 15
(If outside city or town limits, write "RURAL")

(d) Street No. 4473 Gannett
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 40 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 21
year 1940 hour 2 minute A. M.

21. I hereby certify that I attended the deceased from April 8, 1940, to April 22, 1940
and that death occurred on the date and hour stated above.

that I last saw her alive on April 21st, 1940

Immediate cause of death _____

1. Uremia

2. Acute myocarditis

Due to Chronic interstitial hepatitis

Due to Senile Hypertension

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

Major findings: none

Of operations _____

Of autopsy none

Duration

2 weeks

3 weeks

6 years

10 years

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? _____

While at work? _____
(Specify type of place) (e) Means of injury

23. Signature H. J. Shelton (M. D. or other) M.D.

Address 4708 Virginia Date signed 4-22-40

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

MOTHER FATHER

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. 2272

P. O. Address 1726 Allen

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.