

FILED AUG 19 1941

Registration District No. 464

Primary Registration District No. 5558

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Rural Washington Township
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 8215 Locust
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Rural
(If outside city or town limits, write "RURAL")

(d) Street No. 8215 Locust
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME NOBLE BARTLETTE URIE

3. (b) If veteran, name war Spanish American World War (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Maude 6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased Feb. 19, 1878
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 24 year 1941 hour 8 minute 15 a. M.

21. I hereby certify that I attended the deceased from June 20 1941, to June 24 1941 that I last saw him alive on June 24 and that death occurred on the date and hour stated above.

8. AGE: Years 63 Months 4 Days 5 If less than one day hr. _____ min. _____

Immediate cause of death Coronary Occlusion

Duration 4 da

Due to 94 F

9. Birthplace Evansville Indiana
(City, town, or county) (State of foreign country)

10. Usual occupation Retired Soldier.

11. Industry or business U. S. Army

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

MOTHER FATHER { 12. Name George Urie

{ 13. Birthplace Evansville Indiana
(City, town, or county) (State or foreign country)

{ 14. Maiden name Lary Streeter

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

16. (a) Informant Mrs. Maude Urie

(b) Address 8215 Locust

17. (a) Burial (b) Date thereof June 26, 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill

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? _____

18. (a) Signature of funeral director C. H. Blackman & Son, Inc.

(b) Address 2825 Indep. Blvd., K. C. Mo.

19. (a) F 24-24 (b) R. V. Lindsey & Louise
(Date received local registrar) (Registrar's signature)

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

23. Signature S. W. Farr (M. D. or other) _____

Address 484 1/2 W 75 Date signed 6/25/41

SEP 8 1944

OCT 10 1944

MO
X 157

*Dr. Samuel P. ...
Walds
404 1/2 W. 75th*

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 *S. H. Blochman*

Licensed Embalmer No. *2247*

P. O. Address.....

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 25271

Registration District No. 404

Primary Registration District No. 5558

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 8215 Locust, Rural
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. 8215 Locust, Rural
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Robt B. Wrie

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ (if less than one day) _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____ (City, town, or county) (State or foreign country)

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 9-22-41 (b) Maxwell Brennan
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept Day 24 year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I first saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above. (Immediate cause of death) _____

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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 _____ (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTARY

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

OCT 10 1941

5-25271