

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-043245

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3113

FILED NOV 21 1961

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>ST LOUIS</u>	b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>MANCHESTER</u>	a. STATE <u>MO.</u>	b. COUNTY <u>ST LOUIS</u>
Length of stay in lb		c. CITY OR TOWN <u>ST AGNES HOME</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>MANCHESTER NURSING HOME</u>		d. STREET ADDRESS (If outside, give location) <u>10341 MANCHESTER</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH	
First <u>EDWARD</u>	Middle <u>J</u>	Last <u>URBEN</u>	Month <u>NOV</u>	Day <u>3</u> Year <u>1961</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 15, 1873</u>	9. AGE (last birthday) <u>88</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED INSURANCE SALESMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SALESMAN</u>	11. BIRTHPLACE (City and state or country) <u>ST. LOUIS MO.</u>	12. CITIZEN OF WHAT COUNTRY <u>U-S-A</u>
13a. FATHER'S NAME <u>JOHN F URBEN</u>		13b. MOTHER'S MAIDEN NAME <u>MARY GILLESPIE</u>		14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT <u>JOHN F KENNY</u> Address <u>6605 PERIOD AVE</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	<u>Coronary Embolus</u>	<u>1a week</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Myocardial Infarction</u>	
	DUE TO (c) <u>Arteriosclerotic Heart Disease</u>	<u>Doesn't know</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days.
<u>General Arteriosclerosis, Cerebral Emboli</u>		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m.	Month, Day, Year	

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
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21. I attended the deceased from Oct. 17, 1961 to Oct. 31, 1961 and last saw ^{person} him live on Oct. 31, 1961
 Death occurred at 3:15 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Ralph W. Zaffey, M.D.</u>	22b. ADDRESS <u>Box 122, 1016 Man. Rd., Manchester, Mo.</u>	22c. DATE SIGNED <u>11-4-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>NOV. 6 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST. PETER + PAUL CEM.</u>
23d. LOCATION (City, town, or county) <u>ST. LOUIS MO.</u>	25. DATE RECD. BY LOCAL REG. <u>11-4-61</u>	26. REGISTRAR'S SIGNATURE <u>John B. Murphy, M.D.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Thomas Kutis 2906 Gravois</u>		

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 ITEM NO. SHOULD READ

2nd Ed 9111 S. Side
2-4
100-141
Delgado 7-6621

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 _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed *Eleanora Porina*

Licensed Embalmer No. *3403*

P. O. Address *2906 Grand*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.