

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-000433

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 49

STATE FILE NUMBER

FILED JAN 22 1962

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in 1b Life	c. CITY OR TOWN St. Joseph
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 819 South 15th St.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 819 South 15th St.
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last LEO J. URBANSKI			4. DATE OF DEATH Month Day Year January 15, 1962			
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5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9-17-1880	9. AGE (last birthday) 81	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. (10) Fire Chief	10b. KIND OF BUSINESS OR INDUSTRY City Fire Dept.	11. BIRTHPLACE (City and state or country) Aboard Ship Atlantic Ocean enroute to USA	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME Martin Urbanski	13b. MOTHER'S MAIDEN NAME Johannah Wisniewski	14. NAME OF HUSBAND OR WIFE Ann Urbanski
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes Spanish American	16. SOCIAL SECURITY NO.	17. INFORMANT Ann Urbanski	Address 819 So. 15th City
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18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Coronary Occlusion</i>		INTERVAL BETWEEN ONSET AND DEATH <i>STAT</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>Coronary Sclerosis</i>	<i>yes</i>
	DUE TO (c) <i>A.S.H. &amp;</i>	<i>yes</i>
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. <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.) {
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20c. TIME OF INJURY Hour a.m. 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 1950 to Time of Death and last saw him alive on Dec 21 61  
Death occurred at 4:50 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>M.E. Grimes</i>	22b. ADDRESS <i>M. 10 St Joseph Mo</i>	22c. DATE SIGNED <i>Jan 16 62</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Jan. 19, 1962	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d. LOCATION (City, town, or county) (State) St. Joseph, Mo.
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24. FUNERAL DIRECTOR <i>H.O. Sidenfaden &amp; Son</i>	ADDRESS <i>St Joseph, Mo.</i>	25. DATE RECD. BY LOCAL REG. <i>Jan. 18, 1962</i>	26. REGISTRAR'S SIGNATURE <i>Rosa Clark Goodell</i>
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AMENDED  
 DATE AMENDED  
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 DOCUMENT  
 BY AFFIDAVIT OF  
 SHOULD READ  
 ITEM NO.

M.E. Grimes, M.D. MEDICAL CERTIFICATION

R.P.Y.

(Licensed Embalmer's Statement on Reverse Side)

JAN 30 1962

**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 Robert H. Gable  
Licensed Embalmer No. 3308

P. O. Address St. Joseph, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.