

S. No. 2
M-5-43
5-17-39
X36571

3224

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 584
Registrar's No.

FILED FEB 4 1947 318

Registration District No. Primary Registration District No.

1. PLACE OF DEATH:
(a) County St. Louis, Missouri
(b) City or town St. Louis, Missouri
(c) Name of hospital or institution Deaconess Hospital
(d) Length of stay: In hospital or institution

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County
(c) City or town St. Louis
(d) Street No. 8211 Pennsylvania
(e) Citizen of foreign country? (Yes or No)

3. (a) PRINT FULL NAME Jacob Urke
(b) If veteran, name war None
(c) Social Security No. None

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month January day 17th
year 1947 hour 3 p.m. minute M.

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced, widowed
(b) Name of husband or wife Josephine Urke
(c) Age of husband or wife if alive years
7. Birth date of deceased January 19, 1876

21. I hereby certify that I attended the deceased from 5 Jan 1947 to 17 Jan 1947 that I last saw him alive on 17 Jan 1947 and that death occurred on the date and hour stated above.

8. AGE: Years 70 Months 11 Days 28 If less than one day hr. min.

Immediate cause of death Congestive Heart failure
Due to arteriosclerotic cardiovascular disease
Due to

9. Birthplace Illinois
10. Usual occupation Electric Worker
11. Industry or business

Other conditions
Major findings: Of operations
Of autopsy

MOTHER FATHER {
12. Name Bernard Urke
13. Birthplace Illinois
14. Maiden name Caroline LaCraux
15. Birthplace Illinois

PHYSICIAN
Underline the cause to which death should be charged statistically.

16. (a) Informant Mr. Bernard Urke
(b) Address 8211 Pennsylvania
17. (a) Burial (b) Date thereof 1-20-47

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?
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

(c) Place: burial or cremation Mount Hope Cemetery
18. (a) Signature of funeral director Southern Funeral Home
(b) Address 6322 Grand Blvd.
19. (a) (Date received local registrar) (b) J. F. Bredeek (Registrar's signature)

While at work? (Specify type of place) (e) Means of Injury
23. Signature of Registrar (M. D. or other) Date signed 1/18/47

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

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 J. Wm Benkley
Licensed Embalmer No. 3257
P. O. Address St Louis, 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 this body is not embalmed, fact should be so stated above.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. FebRegistration District No. 318Primary Registration District No. 1003Registrar's No. 584

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:
(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)3. (a) PRINT
FULL NAME Jacob Wike3. (b) If veteran,
name war.....3. (c) Social Security
No.....4. Sex m 5. Color or race w
6. (a) Single, widowed, married,
divorced wid6. (b) Name of husband or wife.....
6. (c) Age of husband or wife if
alive.....7. Birth date of deceased Jan 19 1881
(Month) (Day) (Year)8. AGE: Years 70 Months 21 Days 28
If less than one day
hr. min.9. Birthplace.....
(City, town, or county) (State or foreign country)10. Usual occupation Electrician

11. Industry or business.....

12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) (Date received local registrar)..... (b) J. F. Bredetz
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month.....
 year 1947 hour..... minute..... M.21. I hereby certify that I attended the deceased from.....
 to....., 19.....that I last saw him.....
 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?
(Specify type of place)

While at work?..... (e) Means of injury.....

Signature..... (M. D. or other).....

Address..... Date signed.....

Duration

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

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

SUPPLEMENTARY

FEB 17 1947

S-3224

AR-0149