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17-39  
X47070

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED NOV 23 1947

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

40270

State File No. \_\_\_\_\_  
Registrar's No. 10441

Registration District No. 318 Primary Registration District No. 1003

1. PLACE OF DEATH:  
(a) County St. Louis  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution City Infirmary  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 56 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Mrs. Mary Urban  
3. (b) If veteran, name war none  
3. (c) Social Security No. none

4. Sex female 5. Color or race white  
6. (a) Single, widowed, married, divorced widowed  
6. (b) Name of husband or wife late Frederick Urban  
6. (c) Age of husband or wife if alive years 67  
7. Birth date of deceased October 26th, 1871 (Month) (Day) (Year)

8. AGE: Years 76 Months 0 Days 16 If less than one day hr. min.

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

10. Usual occupation Housework

11. Industry or business August Schwandt

12. Name August Schwandt

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

14. Maiden name unknown

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

16. (a) Informant August Urban (b) Address 2610a N. 11th. St.

17. (a) Burial (b) Date thereof 11-15-47 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Peters Cemetery

18. (a) Signature of funeral director Hy. Leidner. U. Co. (b) Address 2223 St. Louis Ave.

19. (a) NOV 13 1947 (Date received local registrar) (b) F. Brudeck (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County  
(c) City or town St. Louis (If outside city or town limits, write "RURAL")  
(d) Street No. 2610a N. 11th. St. (If rural, give location)  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month November day 12th. year 1947 hour 1:00 PM minute 00 P. M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the \_\_\_\_\_ and hour stated above.

Immediate cause of death Chronic Hypertension  
Due to rupture of left chloride artery when she fell to the floor at City Infirmary on Aug 31, 1947 about 4:30 p.m.

Other conditions (Include pregnancy within 3 months of death) 10/6  
PHYSICIAN  
Major findings: Of operations 18  
Of autopsy

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) Accident  
(b) Date of occurrence Aug 31, 1947  
(c) Where did injury occur? City, Mo.  
(d) Did injury occur in or about home, on farm, or industrial place, in public place? City, Mo.

(Specify type of place) While at work? City, Mo. Means of injury  
23. Signature (M.D. or other) Date signed 11/15/47

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

*Wants*

**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 *John P. Buchholz*  
Licensed Embalmer No. *1674*  
P. O. Address *2223 St. Louis Ave*

**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.**