

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

36994

**1. PLACE OF DEATH**

96 County St. Louis Registration District No. 289  
Township Central Primary Registration District No. 6033B  
City (No.     ) St.      Ward     

File No.       
Registered No. 329

**2. FULL NAME**

Matthias Jaros Overland mo.  
(a) Residence, No. 8942 Forest ave. St.      Ward       
(Usual place of abode) (If nonresident, give city or town and State)  
Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? 65 yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widower

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF     

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 15 1851

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>80</u>	<u>15</u>	<u>10</u>	

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Carriage Tinner

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.     

10. Date deceased last worked at this occupation (month and year)      11. Total time (years) spent in this occupation     

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Bohemia Europe

13. NAME Matthias Jaros

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Bohemia Europe

15. MAIDEN NAME Unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Bohemia Europe

17. INFORMANT (ADDRESS) Frank Masek 8942 Forest on Overland mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE: St. Peter & Paul DATE Nov 28 1932

19. UNDERTAKER (ADDRESS) Thos. Kritis 2906 Brown on

20. FILED 11/27 1932 Orilla Gray M.D. Registrar

**3 MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 25<sup>th</sup> 1932

22. I HEREBY CERTIFY, That I attended deceased from Aug 10<sup>th</sup> 1932 to Nov 25<sup>th</sup> 1932

I last saw him alive on Nov 24<sup>th</sup> 1932. Death is said to have occurred on the date stated above, at 5:30 AM

The principal cause of death and related causes of importance were as follows:

Chronic myocarditis  
Carcinoma of Larynx  
Primary  
Metastases of  
Carcinoma to left lung  
Date of onset     

Other contributory causes of importance:     

Name of operation      Date of       
What test confirmed diagnosis? Physical findings Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide?      Date of injury     , 19       
Where did injury occur?      (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.     

Manner of injury       
Nature of injury     

24. Was disease or injury in any way related to occupation of deceased? no  
If so, specify       
(Signed) Arnold H. Wurner, M. D.  
(Address) 8900 St. Charles Rd.

WRITE PLAINLY, WITH UNFADING INK... THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

JAN 5 1933

Please state  
Primary seat  
of carcinoma  
I don't know.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County *St. Louis*  
Township *Central*  
City (No. \_\_\_\_\_) \_\_\_\_\_

Registration District No. *789*  
Primary Registration District No. *60.33B*

File No. \_\_\_\_\_  
Registered No. *329*  
St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

*Matthias Juras*

(a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *wid*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19. \_\_\_\_\_

19. UNDERTAKER (ADDRESS)

20. FILED *11/27* 19 *32* *Opela Bray M.D.* Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *11/25*, 19 *32*

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, to \_\_\_\_\_, 19 \_\_\_\_\_

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19 \_\_\_\_\_ Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

The principal cause of death and related causes of importance were as follows:

*Chronic myocarditis*  
*Coronary artery*  
*Primary*  
*4/7/32*  
Other contributory causes of importance:  
*mitral stenosis of tricuspid*  
*in left lung*

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19 \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased?  
If so, specify \_\_\_\_\_

(Signed) \_\_\_\_\_, M. D.

(Address) \_\_\_\_\_

SUPPLEMENTARY