

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

Do not use this space.

34142

OCT 11 1934

1. PLACE OF DEATH

County .....

Registration District No. **791**  
**1003**

File No. ....

Township .....

Primary Registration District No. *California*

Registered No. **8920**

City *St. Louis* (No. *3141*)

St. .... Ward)

2. FULL NAME *William Mazdra*

(a) Residence, No. *3141 California*, 2<sup>d</sup> Ward.  
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred *27* yrs. mos. ds. How long in U. S., if of foreign birth *27* yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Married*

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Sept 4*, 19*34*

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

22. I HEREBY CERTIFY That I attended deceased from *Aug 31*, 19*34* to *Sept 4*, 19*34*

I last saw him alive on *Sept 4*, 19*34*. Death is said to have occurred on the date stated above, at *12:30* m.

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Aug 25, 1868*

7. AGE YEARS *66* MONTHS DAYS *10* If LESS than 1 day, .....hrs. or .....min.

*Carcinoma of Mesopharynx* Date of onset *Dec 3 1929*

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

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

Other contributory causes of importance: *none*

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

13. NAME *William Mazdra*

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

15. MAIDEN NAME *Catherine Kubat*

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

Name of operation *none* Date of *no*

What test confirmed diagnosis? *path* Was there an autopsy? *no*

17. INFORMANT *Barbara Mazdra* (ADDRESS) *3141 California*

18. BURIAL, CREMATION, OR REMOVAL PLACE *New St. Peter's* (City or town) *Sept 7*, 19*34*

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.

19. UNDERTAKER *Thos. G. G. G.* (ADDRESS) *2906 Brown*

Manner of injury Nature of injury

24. Was disease or injury in any way related to occupation of deceased? *no*

If so, specify (Signed) *W. E. Timp* M. D.

20. FILED *J. P. Bredeck* Registrar.

(Address) *25406 Jefferson*

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.

