

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED JUL 16 1948**  
MISSOURI STATE BOARD OF HEALTH  
**STANDARD CERTIFICATE OF DEATH**

State File No. \_\_\_\_\_

Registration District No. \_\_\_\_\_ Primary Registration District No. 3069

Registrar's No. 1467

1. PLACE OF DEATH:  
(a) County St. Louis  
(b) City or town St. Louis Richmond St  
(c) Name of hospital or institution: St. Marys Hospital  
(d) Length of stay: In hospital or institution 6 Days  
In this community 6 Days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo County Jackson  
(c) City or town Rural Home Springs RR#1  
(d) Street No. \_\_\_\_\_  
(e) Citizen of foreign country? no

3. (a) PRINT FULL NAME JOSEPH FRANK JARUS  
(b) If veteran, name war None  
(c) Social Security No. None

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month July day 7 year 1946 hour \_\_\_\_\_ minute 05 P.M.

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced Widower  
6. (b) Name of husband or wife Catherine Mary Teckara  
6. (c) Age of husband or wife if alive 16 years 1862  
7. Birth date of deceased June (Month) 16 (Day) 1862 (Year)

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

8. AGE: Years 84 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death: Right Cerebral Hemorrhage Hypertension  
Due to 89-a  
Due to \_\_\_\_\_  
Other conditions none  
(Include pregnancy within 3 months of death)

9. Birthplace Bohemia  
10. Usual occupation Retired Farmer  
11. Industry or business Own Farm  
12. Name John Jarus  
13. Birthplace Bohemia  
14. Maiden name Catherine Plzak  
15. Birthplace Bohemia

Major findings:  
Of operations no operation  
Of autopsy no

16. (a) Informant Leo B. Jarus  
(b) Address Home Springs Mo RR#1  
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-4-1946  
(c) Place: burial or cremation St. Johns Cem. Rock Hill Mo  
18. (a) Signature of funeral director John H. Bremer  
(b) Address Home Springs Mo  
19. (a) 7-5-46 (Date received local registrar) (b) J. M. Loran (Registrar's signature)

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) NO  
(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?  
While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_  
23. Signature James H. Wade  
Address 621 North Grand Date signed 7/2/46

Duration 6/25  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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

23661

OCT 1 1946

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 J. Ketter*

Licensed Embalmer No..... 3880

P. O. Address.....

**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.**