

# MISSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-044420  
STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **10785**

**FILED NOV 26 1962**

VS 300  
Rev. 4/59

1

2 **216**

3

4 **0**

5 **1**

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7 **0**

8 **2**

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10

11

12 **97-3**

13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

1. PLACE OF DEATH a. COUNTY		b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY		c. CITY OR TOWN		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
		<b>ST. LOUIS</b>				<b>MO.</b>				<b>ST. LOUIS</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)						Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
<b>ENROUTE CITY HOSPITAL</b>						<b>3146 So. COMPTON</b>									
3. NAME OF DECEASED (Type or print)			First			Middle			Last			4. DATE OF DEATH			
			<b>FRANK</b>			<b>T</b>			<b>JAROS</b>			<b>NOV 9 1962</b>			
5. SEX		6. COLOR OR RACE		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HR			
<b>MALE</b>		<b>WHITE</b>				<b>APR 15 1880</b>		<b>82</b>		Months		Days			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (City and state or country)				12. CITIZEN OF WHAT COUNTRY			
<b>RETIRED PACKER SCRUGGS DEPT. STORE</b>				<b>MISSOURI</b>				<b>U-S-A</b>							
13a. FATHER'S NAME				13b. MOTHER'S MAIDEN NAME				14. NAME OF HUSBAND OR WIFE							
<b>MATHIAS JAROS</b>				<b>UNKNOWN</b>				<b>MARY C JAROS</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT				Address			
<b>NO</b>								<b>MARY JAROS 3146 So. COMPTON</b>							
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY:												INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a)															
<b>Coronary Occlusion</b>															
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.															
DUE TO (b)															
<b>Arterio Sclerosis</b>															
DUE TO (c)															
<b>4201</b>															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)										PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)											
20c. TIME OF INJURY		Hour		Month, Day, Year											
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				20f. CITY, TOWN, OR LOCATION		COUNTY		STATE					
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____		Death occurred at _____ <b>4:10 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title)						22b. ADDRESS			22c. DATE SIGNED						
<b>Helen L. Taylor, Coroner</b>						<b>1308 Clark Ave.</b>			<b>11-9-62</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town, or county) (State)								
<b>REMOVAL</b>		<b>NOV. 12, 1962</b>		<b>RESURRECTION CEM.</b>			<b>ST. LOUIS CO. MO.</b>								
24. FUNERAL DIRECTOR				ADDRESS		25. DATE RECD. BY LOCAL REG.		REGISTRAR'S SIGNATURE							
<b>Thomas Kutis</b>				<b>1906 Gravois</b>		<b>NOV 9 1962</b>		<b>Joan Smith, M.O.</b>							

USE BLACK INK  
OR  
TYPEWRITER RIBBON

**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 \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed J.A. Humphrey

Licensed Embalmer No. 4772

P. O. Address 2906 Gravelis

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.

*Arrows*  
*(City)*