

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

Do not use this space.

1. PLACE OF DEATH

County.....
Township.....
City..... *St. Louis* (No. *City Hosp #1*)

Registration District No. *791*
Primary Registration District No. *1005*

File No. *16511*
Registered No. *4609* Ward

2. FULL NAME

JOSEPH KASZOBOWSKI KASCH
(a) Residence. No. *1400 West W 20* St. *21* Ward. (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 *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Single*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Sept 2 1890*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.
38 7 17

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work *Cornice Maker*
(b) General nature of industry, business, or establishment in which employed (or employer) *In General*
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Poland*

10. NAME OF FATHER *Joseph Kaszubowski*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Poland*

12. MAIDEN NAME OF MOTHER *Maria Gombkowski*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Poland*

14. INFORMANT (Address) *Maria Kaszubowska 1400 West W 20 St*

15. FILED *May 21 1929* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *April 18 1929*

17. I HEREBY CERTIFY, That I attended deceased from 19..... to 19..... that I last saw h..... alive on..... 19..... and that death occurred, on the date stated above, at *545 Q. m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Haemorrhage of Brain (Fractured Skull) Struck by Auto
Dr. Louis M. M. D.
CONTRIBUTORY (SECONDARY) *210 M Accidents* (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED *870 Q. St.* IF NOT AT PLACE OF DEATH.

DID AN OPERATION PRECEDE DEATH? DATE OF..... WAS THERE AN AUTOPSY? *yes*

WHAT TEST CONFIRMED DIAGNOSIS (Signed) *J. W. Kerner M.D.* (Address) *Dep. Coroner*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Calvary* DATE OF BURIAL *April 22 1929*

20. UNDERTAKER *Central Md Co* ADDRESS *846 So*

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.

MARGIN RESERVED FOR BINDING

V.S. NO. 2.

