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

Do not use this space.

39888

File No.

Registered No. 254

**1. PLACE OF DEATH**

County Callaway — Registration District No. 104

Township — Primary Registration District No. 3008

City Fulton (No. ..... St. ..... Ward)

**2. FULL NAME** Mike Kasick

(a) Residence. No. St Louis Mo St., ..... Ward. (If nonresident, give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) No information

| 7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 30 | — | — | |

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) Convict.
(c) Name of employer →

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Slovakia

PARENTS

10. NAME OF FATHER No information

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) No information

12. MAIDEN NAME OF MOTHER No information

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) No information

14. INFORMANT State hospital records
(Address) Fulton Mo

15. Dec 7, 1929 R. N. Crews
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec - 5 - 1929

17. I HEREBY CERTIFY, That I attended deceased from Sept - 20 - 1929, to Dec - 5 - 1929 that I last saw him alive on Dec - 5 - 1929, and that death occurred, on the date stated above, at 8:00 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pulmonary Tuberculosis

31 238 84 (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Dementia Praecox
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? No DATE OF —

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS? X ray plates

(Signed) T. R. Frazer, M. D.

12 6, 1929 (Address) Fulton State Hospital

*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 | DATE OF BURIAL |
|---|---|
| S. S. Peter & Paul Cem St Louis Mo | 12-9 1929 |
| **20. UNDERTAKER** | **ADDRESS** |
| McLaughlin 1631 | Mo ave St Louis Mo |

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.