

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

Do not use this space.

16724

1. PLACE OF DEATH

County..... Registration District No. 791
Township..... Primary Registration District No. 1003
City St Louis (No. 4359 Tapt W.)

File No.....
Registered No. 4664
St. Ward)

2. FULL NAME

Anna (Käsen) Kassen
(a) Residence. No. St. 15 Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>July 4 1854</u>		
7. AGE	YEARS <u>72</u>	MONTHS <u>10</u>
	DAYS <u>13</u>	IF LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>none</u> (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer		
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Germany</u>		
PARENTS	10. NAME OF FATHER <u>Unknown</u>	
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Germany</u>	
	12. MAIDEN NAME OF MOTHER <u>Unknown</u>	
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Germany</u>	

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5/19 1927

17. I HEREBY CERTIFY that I attended deceased from 6:15 to 7:15 on May 19 1927, and that that I last saw her alive on May 18 1927, and that death occurred, on the date stated above, at 3:00 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute cardiocirculation
92A
95B (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) renal degeneration (duration) 10 yrs. mos. da.

18. WHERE WAS DISEASE CONTRAICTED
IF NOT AT PLACE OF DEATH, ...
8 DID AN OPERATION PRECEDE DEATH DATE OF ...
WAS THERE AN AUTOPSY ...
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) Chas. W. Binkley, M. D.
5/18/27 (Address) 4724 Broadway

*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 <u>Our Redeemer</u>	DATE OF BURIAL <u>May 19 1927</u>
20. UNDERTAKER <u>Thos W. Binkley</u>	ADDRESS <u>1936 N. Louis M</u>

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.

14. INFORMANT Mrs. Metchady
(Address) 4359 Tapt W.

15. FILED MAY 18 1927 Max E. Starceoff
Register

