

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

Do not use this space.

3714

1. PLACE OF DEATH

County.....

Registration District No.....

Township.....

Primary Registration District No.....

City, St. Louis (No. 1003)

Little Sisters of Mercy

File No.....

Registered No.....

St.....

Ward.....

2. FULL NAME

Anna A. Fash

(a) Residence, No. 2300 Laurel Blvd. St., 21 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

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Female | White | Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) about 1860

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
about 70

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housework 244

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer Little Sisters of Mercy

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

10. NAME OF FATHER Unknown Fash

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

14.

INFORMANT

(Address)

John J. Matthews
4219A St. Kingshighway Blvd

15.

FILED

21 1931

Max O'Hanley

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 23 1931

17. I HEREBY CERTIFY, That I attended deceased from January 23rd 1931 to January 23rd 1931 that I last saw her alive on January 23rd 1931, and that death occurred, on the date stated above, at 5 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

acute Dilatation of heart
17 hrs (duration) yrs. mos. 3 hrs

CONTRIBUTORY (SECONDARY)

Arterio-Sclerosis (duration) 2 yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? no DATE OF.....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Paul B. Wehbe M. D.

, 19 (Address) 230 Metropolitan Bldg.

*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

Cathary Cemetery

1-26 1931

20. UNDERTAKER

ADDRESS 4228

Kueyschauer & Co. St. Kingshighway

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.

THIS IS A PERMANENT RECORD

