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

Do not use this space.

13423

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St Louis (No. 4519 N Market St. ..... St. ..... Ward)

File No. .....

Registered No. 3750

2. FULL NAME John Henry Fahien

(a) Residence. (No. ..... St., 11 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. 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	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 3 1864

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	62	8	13	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Merchant

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

(c) Name of employer Confectionary Store

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

PARENTS

10. NAME OF FATHER J H. Fahien

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Minnie Fahien (Address) 4519 N. Market St.

15. FILED APR 19 1927 Max C Starkloff REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 16th 1927

17. I HEREBY CERTIFY, That I attended deceased from March 9th, 1927, to April 16th, 1927 that I last saw him alive on April 16th, 1927 and that death occurred, on the date stated above, at 10 30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Chronic interstitial Nephritis

131

Sp. 1290

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Apoplexy Cerebral

Hemorrhage (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....

8 DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) [signature], M. D

April 18, 1927 (Address) 4000 St Louis Av

*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
St. Peters Cemetery	4/19/27 19
20. UNDERTAKER	**ADDRESS**
Theo. W. Beiderwieden	1936 St. Louis Ave

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.

[illegible] THIS IS A PERMANENT RECORD