

FILED FEB 24 1947

State File No. \_\_\_\_\_

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **1672**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County St. Louis Mo  
(b) City or town St. Louis Mo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Barnes Hospital, O  
(If not in hospital or institution, write street number & location)  
(d) Length of stay: In hospital or institution 7 hours  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County oao  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL") 147  
(d) Street No. 5747 Walsh  
(If rural, give location) 9  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Anna Agnes Fairchild

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased. Dec. 2 1881  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
65 2 14 \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace St. Louis Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Hwk.

11. Industry or business \_\_\_\_\_

12. Name Benigo Zarracina

13. Birthplace Spain  
(City, town, or county) (State or foreign country)

14. Maiden name Catherine Iost  
(City, town, or county) (State or foreign country)

15. Birthplace Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant Russell Fairchild

(b) Address 2408 So 18th St.

17. (a) Burial (b) Date thereof 2/19/47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation. Calvary Cemetery

18. (a) Signature of funeral director. Francis Beck

(b) Address 3029 Lafayette

19. (a) FEB 18 1947 J. F. Brueck  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 16  
year 1947 hour 1 minute 55 A.M.

21. I hereby certify that I attended the deceased from March 8, 1946 to Feb 16, 1947  
that I last saw her alive on Feb 16, 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis Duration 10 days

Due to Coronary arteriosclerosis

Due to \_\_\_\_\_

Other conditions Hypertensive C.V.D.  
(Include pregnancy within 6 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy Coronary thrombosis

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature Patricia J. Lamer (M. D. or other)

Address Barnes Hospital Date signed 2/16/47

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed

*David VanFossan*

Licensed Embalmer No. *4247*

P. O. Address *3029 24th St*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**