

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

Do not use this space.

3094

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City *St. Louis* (No. *4752 W. Florissant Ave.* St. _____ Ward)

2. FULL NAME *Christina Figgemeier*

(a) Residence. No. *4752 W. Florissant Ave.* St. _____ 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 *Female*
 4. COLOR OR RACE *white*
 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *widow*
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Anton Figgemeier*
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) *April 11 - 1853*
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
76 9 5

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work..... *Home work*
 (b) General nature of industry, business, or establishment in which employed (or employer).....
 (c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN)..... *St. Louis Mo*
 (STATE OR COUNTRY)

10. NAME OF FATHER..... *Fred Fisher*

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

12. MAIDEN NAME OF MOTHER..... *Bertrude Pieper*

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

14. INFORMANT..... *Anton Figgemeier*
 (Address) *4752 W. Florissant Ave.*

15. FILED: *JAN 18 1930*
Wm C Stanley
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *1 - 16 - 1930*
 17. I HEREBY CERTIFY, That I attended deceased from *Jan 1*, 192*9*, to *Jan 16*, 1930, that I last saw her alive on *Jan 16*, 1930 and that death occurred, on the date stated above, at *7-55 P* m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Central Hemorrhage
"apoplexy"
 82.A (duration) yrs. *6* mos. ds.

CONTRIBUTORY (SECONDARY) *74*
 (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) *A. J. Beck*, M. D.

Jan 18, 1930 (Address) *415 E W Florissant*

*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..... *Calvary* DATE OF BURIAL..... *Jan 20 1930*

20. UNDERTAKER..... *Personschurg and Co* ADDRESS..... *4540 St. Florissant*

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.

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