DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

REC'D NOV 13 1939 791

Registration District No. 1008

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 33912

Primary Registration District No.

Registrar's No. 8450

**1. PLACE OF DEATH:**

(a) County

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1929 Congress St.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days) In this community Life.

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County

(c) City or town St. Louis. 23
(If outside city or town limits, write "RURAL")

(d) Street No. 1929 Congress St.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Annie Wigge

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 Widow

6. (b) Name of husband or wife Frank Wigge

6. (c) Age of husband or wife if alive years

7. Birth date of deceased May 15 (Month) 1858 (Day) (Year)

8. AGE: Years 81 Months 4 Days 18 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business At Home

FATHER
12. Name Frank Wigge
13. Birthplace Germany (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Elizabeth Werner
15. Birthplace Germany (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Lilly Wigge
(b) Address 1929 Congress St.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof Oct 5/39 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cem.

18. (a) Signature of funeral director Thos Kutis
(b) Address 2906 Gravois Ave.

19. (a) OCT 3 1939 (Date received local registrar) J. F. Bochek (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Oct 2 day year 1939 hour 11 50 A.M. minute M.

21. I hereby certify that I attended the deceased from Feb 23, 1936 to October 2, 1939 that I last saw her alive on October 1, 1939 and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death: Chronic Parenchymatous Nephritis | 4 yrs |
| Due to | |
| Due to | |
| Other conditions (Include pregnancy within 3 months of death): Chronic Myocarditis, Arterio-sclerosis | 3 yrs |
| Major findings: Of operations | |
| Of autopsy | |

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

23. Signature J. P. Kerr M.D. (M. D. or other)
Address 2730 McNAIR AVE Date signed 10-2-39

(Licensed Embalmer's Statement on Reverse Side)

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.

## 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 THOS. KUTIS., Registered Apprentice No. ..... working under my personal supervision.

Signed Thos Kutis

Licensed Embalmer No. 1619

P. O. Address 2906 Gravois Ave.

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

**If this body is not embalmed, above space should be left blank.**