

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

1 PLACE OF DEATH

County

Township

or

Village

or

City *St Louis* (NO. *614*)

Registration District No. *791*

File No. *14531*

Primary Registration District No. *1003*

Registered No. *3568*

City *City Hospital* (NO. *614*)

Ward *2*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME *Frank Figgemeier*

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX *Male*
4 COLOR OR RACE *White*
5 SINGLE MARRIED *Married*
WIDOWED OR DIVORCED (Write the word)

16 DATE OF DEATH *April 15 1915*
(Month) (Day) (Year)

6 DATE OF BIRTH *April 22 1874*
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from *April 12 1915* to *April 15 1915*
that I last saw *him* alive on *April 14 1915*

7 AGE *40 yrs 11 mos 21 ds*
If LESS than 1 day.....hrs. or.....min.?

and that death occurred, on the date stated above, at *5²⁵ A*

The CAUSE OF DEATH* was as follows:

8 OCCUPATION (a) Trade, profession, or particular kind of work *Laborer*
(b) General nature of industry business or establishment in which employed (or employer) *Day*

Chronic alcoholism

9 BIRTHPLACE (City or town, State or foreign country) *St Louis*

(Duration).....yrs.....mos.....ds.

10 NAME OF FATHER *Antonie Figgemeier*

CONTRIBUTORY (Secondary) (Duration).....yrs.....mos.....ds.

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) *Germany*

(Signed) *W. A. M. D.*

12 MAIDEN NAME OF MOTHER *Christina Ginter*

(Address) *City Hospital*

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) *Germany*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) *W. A. M. D.*

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death.....yrs.....mos.....3 ds. In the *40* State.....yrs.....mos.....ds.

Where was disease contracted if not at place of death?.....

Former or usual residence *3914 N 11*

19 PLACE OF BURIAL OR REMOVAL *Calvary Cem* DATE OF BURIAL *April 14 1915*

20 UNDERTAKER *Edward Koch* ADDRESS *3516 N 14th*

Filed *Apr 16 1915* *Max B. Stackloff* Registrar