

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

Do not use this space.

35456

1. PLACE OF DEATH

County.....
Township.....
City..... *St. Louis*

Registration District No. **791**
Primary Registration District No. **1003**

File No.....
Registered No. **10513**
St. Ward)

2. FULL NAME

William John Figg
(a) Residence. No. *5253 - Lansdowne Ave.* St. Ward.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Magdalena Figg*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Nov 27 - 1862*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
65 10 28

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work *Carpenter 47A*
(b) General nature of industry, business, or establishment in which employed (or employer) *Wood Worker 105A*
(c) Name of employer

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

10. NAME OF FATHER *Unknown*

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

12. MAIDEN NAME OF MOTHER *Unknown*

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

14. INFORMANT *Magdalena Figg*
(Address) *5253 - Lansdowne Ave*

15. FILED *26 1928* *May B. Starckoff*
19... Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Oct 24 1928*

17. I HEREBY CERTIFY That I attended deceased from *Oct 22* 1928 to *Oct 24* 1928 that I last saw him alive on *Oct 24* 1928, and that death occurred, on the date stated above, at *9:20 p.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Broncho pneumonia
Operation for cancer of the
Larynx

CONTRIBUTORY (SECONDARY) *Tracheotomy*
Styngotomy (duration) yrs. mos. da. *3*

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? *St. Luke's Hosp. St. Louis*

1 DID AN OPERATION PRECEDE DEATH? *yes* DATE OF *Oct 24 1928*

WAS THERE AN AUTOPSY? *Only partial - Examination of patient*

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) *E.O. Mastin*, M. D.
10/16, 1928 (Address) *1048 Missouri Bldg -*

*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 *Oct 27 1928*

20. UNDERTAKER *Wacker-Heldorfs* ADDRESS *2331-5 Bldg*

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.

