DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FEB 25 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 726

Registration District No. 791 — Primary Registration District No. 1003 — Registrar's No. 726

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

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: Lutheran Hosp. (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether

In this community 5 Hrs. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jefferson

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

(d) Street No. Route 2 (If rural, give location)

(e) If foreign born, how long in U. S. A.? 1 years.

3. (a) PRINT FULL NAME Willard Joseph Figge,

3. (b) If veteran, name war None

3. (c) Social Security No. 492-03-4782

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife

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

7. Birth date of deceased Aug. 12. 1915 (Month) (Day) (Year)

8. AGE: Years 25 Months 5 Days 10 If less than one day hr. min.

9. Birthplace St. Genevieve, (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Laborer

11. Industry or business Cement Co.

FATHER
12. Name Joseph X. Figge.
13. Birthplace (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name Mary E. Karl
15. Birthplace (City, town, or county) Missouri (State or foreign country)

16. (a) Informant Joseph X. Figge,

(b) Address St. Genevieve, Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 1/23/41 (Month) (Day) (Year)

(c) Place: burial or cremation St. Genevieve, Mo.

18. (a) Signature of funeral director [signature]

(b) Address 2117 E. Grand Blvd.

19. (a) JAN 23 1941 (Date received by Registrar) (b) J F Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 22 year 1941 hour 10 minute 05 P.M.

21. I hereby certify that I attended the deceased from ....., 19...., to ....., 19....; that I last saw h..... alive on ....., 19....; and that death occurred on the date and hour stated above.

Immediate cause of death: Shock due to Hemorrhage from soft Parts of the Left

Due to Axilla when he was Injured by a belt at a Time

Due to Kilm (Name Unknown) at St Genevieve Missouri

Other conditions (Include pregnancy within 3 months of death) about 10:00 Oclock am Jan 22nd 1941. Cause and

Major findings: Of operations Manner Could not be Determined

Of autopsy

Duration

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) accident

(b) Date of occurrence Jan 22-1941

(c) Where did injury occur? St Genevieve Mo (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Industrial Place (Specify type of place)

While at work? (e) Means of injury

23. Signature [signature] (M. D. or other)

Address [signature] Date signed 1/23/41

(Licensed Embalmer's Statement on Reverse Side)

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 Frank A. Moore

Licensed Embalmer No. 3041

P. O. Address 2117 E Stan

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, above space should be left blank.

S. No. 2B
M—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 126

Registration District No. 791 Primary Registration District No. 1003 Registrar's No.

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: Lutheran
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jefferson
(c) City or town St Genevieve Mo
(If outside city or town limits, write "RURAL")
(d) Street No. R
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Willard Joseph Figge
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced S
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased aug (Month) 12 (Day) 1915 (Year)

8. AGE: Years 25 Months 5 Days If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
12. FATHER Name
13. FATHER Birthplace (City, town, or county) (State or foreign country)
14. MOTHER Maiden name
15. MOTHER Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) NOV 21 1941 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 22 year 1941 hour minute M.
21. I hereby certify that I attended the deceased from 19 to 19; that I last saw him alive on 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

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 (M. D. or other)
Address Date signed

SUPPLEMENTARY

gal