

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

Do not use this space.

38245

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **St. Louis**

(No. **No. Baptist Sanitariums** St. _____ Ward)

File No. _____

Registered No. **10890**

2. FULL NAME

Mary C. Friend

(a) Residence. No. **4313 N. Papin 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)

Married

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

Henry Friend

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

July 17, 1882

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, _____ hrs. or _____ min.

45

4

16

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

At Home

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Unknown

10. NAME OF FATHER

Maurice Sullivan

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Albany N.Y.

12. MAIDEN NAME OF MOTHER

Jane O'Leary

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Massachusetts

14.

INFORMANT

(Address)

**Hesary Friend
4313 N. Papin St.**

15.

DEC - 5 1921

FILED

19

Mar. 6 Starkeff
REGISTERAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

Dec. 3 1927

17.

I HEREBY CERTIFY, That I attended deceased from **Oct**

1st, 19**27**, to **Dec 3rd**, 19**27** that I last saw him alive on **Dec 2nd**, 19**27**, and that death occurred, on the date stated above, at **2:25 A.M.**

THE CAUSE OF DEATH WAS AS FOLLOWS:

Lobar Pneumonia
12 1/2 (duration) yrs. mos. ds.
10 1/2

CONTRIBUTORY (SECONDARY)

Removal of Gall Bladder for Gallstones (duration) **1** yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

1 DID AN OPERATION PRECEDE DEATH? **Yes** DATE OF **11-30-27**

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS **Physical Signs**

(Signed) **J. S. Smith**, M. D.

12-5, 19**27** (Address) **4575 Chestnut**

*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

DATE OF BURIAL

Calvary Cemetery **Dec 6 1927**

20. UNDERTAKER

ADDRESS

Krieghouser and Co **Manchester**

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.

WHITE PENCIL, WITH UNFADING INK—THIS IS AN PERMANENT RECORD

20

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