

FILED MAR 5 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 6182  
1806

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY 0-20			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis		c. LENGTH OF STAY (In this place) 20 yrs		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis 17	
d. FULL NAME OF HOSPITAL OR INSTITUTION 2352 Park Avenue		d. STREET ADDRESS (If rural, give location) 2352 Park Avenue 3			
3. NAME OF DECEASED (Type or Print) a. (First) John b. (Middle) C. c. (Last) Friend		4. DATE OF DEATH (Month) (Day) (Year) Feb. 24-1949			
5. SEX m	6. COLOR OR RACE w	7. MARRIED, NEVER MARRIED; WIDOWED, DIVORCED (Specify) m	8. DATE OF BIRTH May 1-1863	9. AGE (In years last birthday) 85	IF UNDER 1 YEAR: Days 9
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Lancaster, Ohio	
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME Geo. W. Friend		13b. MOTHER'S MAIDEN NAME Unknown	
14. NAME OF HUSBAND OR WIFE Jennie		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME Jennie Friend		18. ADDRESS 2352 Park Ave			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) La Grippe			INTERVAL BETWEEN ONSET AND DEATH 16 day
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Egg Arteriosclerosis		DUE TO (b) Infection			DUE TO (c)
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION none			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) No		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY		21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 2-4, 1949, to 2-24, 1949, that I last saw the deceased alive on 2-24, 1949, and that death occurred at 9P m., from the causes and on the date stated above.					
23a. SIGNATURE B. Shanklin M.D.		23b. ADDRESS 1514 S Jefferson Ave		23c. DATE SIGNED 2/25/49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 2-26-49		24c. NAME OF CEMETERY OR CREMATORY Mount Hope	
24d. LOCATION (City, town, or county) (State) St Louis County, MO		25. FUNERAL DIRECTOR'S SIGNATURE U.S. McLaughlin		25. ADDRESS 2301 N. Jayette	

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

**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.....

Student Embalmer No. ....

working under my personal supervision. .

Student .....  
Student Embalmer

Signed.....

*A W Cooper*

Licensed Embalmer No. *3880*

P. O. Address *2301 Lafayette*

**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, fact should be so stated above.