

FILED JUL 14 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 22231
Registrar's No. 216

BIRTH NO. _____		REG. DIST. NO. 323		PRIMARY REG. DIST. NO. 4474		Registrar's No. 216	
1. PLACE OF DEATH a. COUNTY <u>SALINE</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>SALINE</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>SWEET SPRINGS</u>		c. LENGTH OF STAY (in this place) <u>8 yrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>SWEET SPRINGS</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>129 S. DAISEY AVE</u>				d. STREET ADDRESS (If rural, give location) <u>129 S. DAISEY AVE</u>			
3. NAME OF DECEASED (Type or Print) <u>JAMES</u>		a. (First) <u>ADAM</u>		c. (Last) <u>FRIEDLY</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>JULY 8, 1949</u>	
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>JAN. 26, 1879</u>	
9. AGE (In years last birthday) <u>70</u>		10. MONTHS <u>5</u>		11. DAYS <u>12</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TILLER of SOIL</u>		11. BIRTHPLACE (State or foreign country) <u>MORGAN Co. Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>AG. D. FRIEDLY</u>		13b. MOTHER'S MAIDEN NAME <u>CORDELLA BEATY</u>		14. NAME OF HUSBAND OR WIFE <u>DAISY D. FRIEDLY</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. W. Turner. Rm 74</u>			
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) <u>Congestive heart failure</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic H.D.</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>4200</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		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 (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 7, 1949</u> , to <u>July 8, 1949</u> , that I last saw the deceased alive on <u>July 8, 1949</u> , and that death occurred at <u>7:15 P.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree of title) <u>Joseph P. Doyle, M.D.</u>		23b. ADDRESS <u>Sweet Springs, Mo.</u>		23c. DATE SIGNED <u>July 9, 49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>JULY 10 - 49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>FRIEDVIEW</u>		24d. LOCATION (City, town, or county) (State) <u>SWEET-SPRINGS Mo</u>	
DATE REC'D BY LOCAL REG. <u>7/9/49</u>		REGISTRAR'S SIGNATURE <u>Dolly Anderson</u>		FUNERAL DIRECTOR'S SIGNATURE <u>R. C. CARTER</u>		ADDRESS <u>Sweet Springs</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED JUL 12
District Health Officer No. 8,

District File Number.....

Date Filed 7-13-49.....

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

R. Carter

Licensed Embalmer No. 3513

P. O. Address *St. Louis Mo.*

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.