

FILED DEC 6 1949

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

State File No. **38727**  
**10153**

|   |  |   |                  |   |                                  |   |                        |  |
|---|--|---|------------------|---|----------------------------------|---|------------------------|--|
| BIRTH NO. _____   |  | REG. DIST. NO. <b>318</b>   |                  | PRIMARY REG. DIST. NO. <b>1002</b>  |                                  | Registrar's No. _____   |                        |  |
| 1. PLACE OF DEATH<br>a. COUNTY _____  |  |   |                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <b>Mo.</b><br>b. COUNTY <b>B.</b> |                                  |   |                        |  |
| b. CITY (If outside corporate limits, write RURAL and give OR TOWN <b>St. Louis</b> )   |  | c. LENGTH OF STAY (In this place) _____   |                  | c. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b>   |                                  |   |                        |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Stone Nursing Home</b>   |  |   |                  | d. STREET ADDRESS (If rural, give location) <b>16-4256 Juniata St.</b>  |                                  |   |                        |  |
| 3. NAME OF DECEASED<br>(Type or Print) <b>MARY</b>  |  |   | a. (First) _____ |   | b. (Middle) <b>(Aunt Mollie)</b> |   | c. (Last) <b>FRIES</b> |  |
| 4. DATE OF DEATH  |  | (Month) _____ (Day) <b>23</b> (Year) <b>1949</b>  |                  | 5. SEX <b>Female</b>  |                                  | 6. COLOR OR RACE <b>White</b>   |                        |  |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widow</b>   |  | 8. DATE OF BIRTH <b>June 5, 1857</b>  |                  | 9. AGE (In years last birthday) <b>92</b>   |                                  | IF UNDER 1 YEAR Months <b>5</b> Days <b>18</b>                        |                        |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY _____   |                  | 11. BIRTHPLACE (State or foreign country) <b>St. Louis, Mo.</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY? _____                                    |                        |  |
| 13a. FATHER'S NAME <b>John Carroll</b>  |  | 13b. MOTHER'S MAIDEN NAME <b>Mary Flynn</b>   |                  | 14. NAME OF HUSBAND OR WIFE <b>Late Martin Fries</b>  |                                  |   |                        |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>   |  | 16. SOCIAL SECURITY NO. <b>None</b>   |                  | 17. INFORMANT'S SIGNATURE OR NAME <b>Miss Alice Cook</b> ADDRESS <b>4256 Juniata St.</b>  |                                  |   |                        |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br><i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>                                  |  | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Chronic Myocardial Disease</b>   |                  |   |                                  | INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b>                      |                        |  |
|   |  | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____ |                  |   |                                  |   |                        |  |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.   |  |   |                  |   |                                  |   |                        |  |
| 19a. DATE OF OPERATION _____  |  | 19b. MAJOR FINDINGS OF OPERATION _____  |                  |   |                                  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) <b>93</b> (STATE) <b>Mo.</b>  |                                  |   |                        |  |
| 21d. TIME OF INJURY (Month) _____ (Day) _____ (Year) _____ (Hour) _____   |  | 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 <b>about Sept. 19, 1949</b> to <b>Nov. 27, 1949</b> , that I last saw the deceased alive on <b>Nov. 23, 1949</b> , and that death occurred at <b>11:00 pm.</b> , from the causes and on the date stated above. |  |   |                  |   |                                  |   |                        |  |
| 23a. SIGNATURE <b>Paul B. Webb, M.D.</b> (Degree or title) _____  |  |   |                  | 23b. ADDRESS <b>1915<sup>a</sup> Silvery St.</b>  |                                  | 23c. DATE SIGNED <b>11/25/49</b>                                      |                        |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  | 24b. DATE <b>Nov. 26, 1949</b>  |                  | 24c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>  |                                  | 24d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>   |                        |  |
| DATE REC'D BY LOCAL REG. <b>NOV 25 1949</b>   |  | REGISTRAR'S SIGNATURE <b>J. B. Farnham</b>  |                  | 25. FUNERAL DIRECTOR'S SIGNATURE <b>Kriegshauser</b> ADDRESS <b>4228 S. Kingshighway Bl</b>   |                                  |   |                        |  |

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

1915  
Sweeney St.  
10-12  
COCOA 104 W

**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 William A. White

Licensed Embalmer No. 4291

P. O. Address 4228 S. Kingshigh

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.