

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-015797  
STATE FILE NUMBER  
4184

FILED APR 23 1958

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4184

300  
-57)

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
8. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Deaconess Hospital</b>		Length of stay in lb <b>20 yrs</b>	
d. STREET ADDRESS <b>2674</b>		(If outside, give location) <b>4273 Wyoming Avenue</b>	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED First Middle Last <b>REV. JULIUS A. FRIEDRICH</b>			4. DATE OF DEATH Month Day Year <b>April 14, 1958</b>
5. SEX <b>male 0</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2-DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 9, 1862</b>
9. AGE (In years last birthday) <b>96</b>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Minister</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Lutheran Church</b>	11. BIRTHPLACE (City and state or country) <b>Huntington, Indiana</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13a. FATHER'S NAME <b>Rev. Edward J. Friedrich</b>		13b. MOTHER'S MÄDEN NAME <b>Sophie Wille</b>	
14. NAME OF HUSBAND OR WIFE <b>Bertha Schick</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>---</b>	
17. INFORMANT Address <b>Paul Friedrich, 729 Fieldstone Terrace</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocarditis Arteriosclerotic</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Coronary Heart disease</b> DUE TO (c) <b>Uremia + Anuria</b>			INTERVAL BETWEEN ONSET AND DEATH <b>years</b> <b>48 Hrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Uremia + Anuria</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <b>1957</b> to <b>April 14-1958</b> and last saw him alive on <b>April 14-1958</b> Death occurred at <b>8:57 PM</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Arnold E. Klein M.D.</b>		22b. ADDRESS <b>2632 St. Louis Highway</b>	
22c. DATE SIGNED <b>4/15/58</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>		23b. DATE <b>Apr. 17, 1958</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Immanuel Lutheran Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Charles, Mo.</b>	
24. FUNERAL DIRECTOR ADDRESS <b>BEIDERWIEDEN F.H. INC., 1936 St. Louis Ave</b>		25. DATE RECD. BY LOCAL REG. <b>APR 16 '58</b>	
26. REGISTRAR'S SIGNATURE <b>Paul Smith M.D.</b>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

1-4 pm  
2632  
Dr. Arnold J. Klein  
~~2679~~ So. Kingshighway

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 .....  
Signature of Student Embalmer

Signed *Gustav W. Diet* .....

Licensed Embalmer No. *4379*  
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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.