

INDEXED

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		a. STATE Mo.	b. COUNTY St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		c. CITY OR TOWN Normandy, Mo.	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
Length of stay in 1b		d. STREET ADDRESS (if outside, give location) 5317 Colton Dr.,	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH	
First	Middle	Last	Month	Day
ETHEL	NANCY	FRIEDRICH	JULY	26
Year	Year			
1960	1960			
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12/15/1914	9. AGE (last birthday) 45
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY

13a. FATHER'S NAME Calvin Derrick	13b. MOTHER'S MAIDEN NAME Zona Blackburn	14. NAME OF HUSBAND OR WIFE Harold Karl Friedrich
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 488-10-6981	17. INFORMANT Address Harold K. Friedrich 5317 Colton Dr.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) POST-OPERATIVE ENDARTERECTOMY WITH HEMORRHAGE		18 HOURS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) RUPTURED ABDOMINAL AORTA	12 HOURS
	GENERALIZED ARTERIOSCLEROSIS WITH OCCLUSION OF	
DUE TO (c) THE AORTA		2 YEARS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) HYPERTENSIVE CARDIOVASCULAR DISEASE		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
---	--	---

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.) 454x
---	---	---

20c. TIME OF INJURY Hour 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 **JULY 22, 1960** to **JULY 26, 1960** and last saw her/him alive on **JULY 26, 1960**
 Death occurred at **8:15 A.M.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>C. J. Smith, M.D.</i>	(Degree or title) M. D.	22b. ADDRESS BARNES HOSPITAL	22c. DATE SIGNED 7/26/60
--	-----------------------------------	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE July 26th, 1960	23c. NAME OF CEMETERY OR CREMATORY Laurel Hill Garden	23d. LOCATION (City, town, or county) 2000 N. Pennsylvania, Mo.
---	-------------------------------------	---	---

24. FUNERAL DIRECTOR Harry A. Kraeger	ADDRESS 24 Chapel Hill	25. DATE RECD. BY LOCAL REG. JUL 27 1960	26. REGISTRAR'S SIGNATURE <i>Carl Smith, M.D.</i>
---	----------------------------------	--	--

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

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 Stanley H. [Signature]

Licensed Embalmer No. 4193

P. O. Address [Signature]

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.