

FILED AUG 20 1954

RC-9312 924

Reg.#1588 SL 1459

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

28896

BIRTH NO. .... REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **6268**

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>ST. LOUIS</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>915 N. Grand, St. Louis, Mo.</b>		c. CITY OR TOWN <b>UNIVERSITY CITY</b>	
c. LENGTH OF STAY (in this place) <b>42 days</b>		d. Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>VETERANS ADMINISTRATION HOSP.</b>		e. STREET ADDRESS (If rural, give location) <b>1422 ANNA</b>	

3. NAME OF DECEASED (Type or Print)	a. (First) <b>CLEMENS</b>	b. (Middle) <b>H.</b>	c. (Last) <b>FRIEDMAN</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>JULY 11, 1954</b>
-------------------------------------	---------------------------	-----------------------	---------------------------	---

5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>8/29/02</b>	9. AGE (In years last birthday) <b>51</b>	IF UNDER 1 YEAR Months Days	IF UNDER 2 WKS. Hours Min.
--------------------	-------------------------------	---	---------------------------------	---	-----------------------------	----------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INSURANCE BROKER</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <b>ST. LOUIS, MISSOURI</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
---	-----------------------------------	---	---

13a. FATHER'S NAME <b>CLEMENS FRIEDMAN</b>	13b. MOTHER'S MAIDEN NAME <b>DINA STILLMAN</b>	14. NAME OF HUSBAND OR WIFE <b>ALYCE K. FRIEDMAN</b>
--	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <b>YES WW-2</b>	16. SOCIAL SECURITY NO. <b>UNKNOWN</b>	17. INFORMANT'S SIGNATURE OR NAME <b>VA HOSP. RECORDS, ST. LOUIS, MO.</b>	ADDRESS
--	--	---	---------

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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>PERITONITIS, GENERALIZED</b>		<b>3 weeks</b>
	ANTECEDENT CAUSES DUE TO (b) <b>PERFORATION OF DUODENAL STUMP</b>		<b>3 weeks</b>
	DUE TO (c) <b>COMPLICATION OF SUBTOTAL GASTRIC RESECTION FOR DUODENAL ULCER</b>		<b>11 years</b>
II. OTHER SIGNIFICANT CONDITIONS <b>RESECTION FOR DUODENAL ULCER</b> Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION <b>6/8/54</b>	19b. MAJOR FINDINGS OF OPERATION <b>POSTERIOR PENETRATING DUODENAL ULCER</b>	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) <b>VA</b>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>S410</b>
---	--	--

22. I hereby certify that I attended the deceased from **5/30**, 19 **54**, to **7/11**, 19 **54**, that death was the result of ~~the above causes~~ and that death occurred at **1:45 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE <b>W. E. Lucas, M.D.</b> (Degree or title)	23b. ADDRESS <b>VAH, ST. LOUIS, MO.</b>	23c. DATE SIGNED <b>7/11/54</b>
---	---	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	24b. DATE <b>7-13-54</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis Co., Mo.</b>
--	--------------------------	--	---

DATE REC'D BY LOCAL REG. <b>JUL 12 1954</b>	REGISTRAR'S SIGNATURE <b>Carl Smith MO</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Berger Memorial</b>	ADDRESS <b>4715 McPherson Ave.</b>
---	--	---	------------------------------------

(Licensed Embalmer's Statement on Reverse Side)

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.....  
Signature of Student Embalmer

Signed 

Licensed Embalmer No. 422

P. O. Address .....

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.