

1. PLACE OF DEATH a. COUNTY Bexar		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Texas b. COUNTY Bexar	
b. CITY OR TOWN (If outside city limits, give precinct no.) San Antonio		c. LENGTH OF STAY in 1 b. Life	
d. NAME OF (If not in hospital, give street address) HOSPITAL OR INSTITUTION Baptist Memorial Hospital		d. STREET ADDRESS (If rural, give location) 1035 Bailey Ave.	
e. IS PLACE OF DEATH INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		e. IS RESIDENCE INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) (a) First ARTHUR (b) Middle EDWIN (c) Last FRIED			4. DATE OF DEATH October 9, 1970		
5. SEX Male		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 July 23, 1897			9. AGE (In years last birthday) 73		IF UNDER 1-YEAR Months Days Hours Minutes
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shop Foreman, ret. Public Service			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Texas
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME George W. Fried		
14. MOTHER'S MAIDEN NAME Edith Cowdry			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. 455-05-5638A			17. INFORMANT Mrs. A. E. Fried		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) TEXAS DEPARTMENT OF HEALTH IMMEDIATE CAUSE (a) Hemorrhage REG'D NOV. 5 1970 which gave rise to above cause (a) BUREAU OF VITAL STATISTICS DUE TO (b) Cortic aneurysm (c) arteriosclerosis generalisid		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		

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 building, etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	

21. I hereby certify that I attended the deceased from <u>1960</u> to <u>October 9</u> , <u>1970</u> and last saw the deceased alive on <u>Oct-9</u> , <u>1970</u> . Death occurred at <u>11:45 P.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE C.R. Letteer, MD (Degree or title) <i>C.R. Letteer</i>		22b. ADDRESS 606 M & S Tower San Antonio, Texas
		22c. DATE SIGNED 10-12-70

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE October 12, 1970	23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park	
23d. LOCATION (City, town, or county) (State) San Antonio Texas		24. FUNERAL DIRECTOR'S SIGNATURE Porter Loring Mortuary <i>Terrell Hobbs</i>		
25a. REGISTRAR'S FILE NO. 5091	25b. DATE REC'D BY LOCAL REGISTRAR OCT 12 70		25c. REGISTRAR'S SIGNATURE <i>G. M. Wainwright</i>	

TEXAS DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

MEDICAL CERTIFICATION

FORM REV. 7-59