

Denwick

REC'D MAR 13 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

6548
Do not use this space.

1. PLACE OF DEATH

(a) County GRENF Registration District No. 316
(b) Township SPRINGFIELD Primary Registration District No. 2001
(c) City SPRINGFIELD (d) Street No. 1093 S. National St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 06.3 Kay Brooks Rader

(a) Residence, No. 1093 S. National St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Child

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 5th 1932

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
✓ 6 11 12

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) Springfield (STATE OR COUNTRY) Missouri

FATHER 13. NAME J. C. Rader

14. BIRTHPLACE (CITY OR TOWN) Conway (STATE OR COUNTRY) Mo.

MOTHER 15. MAIDEN NAME Gladys Brooks

16. BIRTHPLACE (CITY OR TOWN) Henderson (STATE OR COUNTRY) Mo.

17. INFORMANT (ADDRESS) J. C. Rader
Springfield Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Maple Park DATE Feb 19th, 1939

19. FUNERAL DIRECTOR (NAME) Herman Lohmeyer (ADDRESS) Springfield Mo.

20. FILED Feb 19 1939 Chas. George Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 17th 1939

22. I HEREBY CERTIFY, That I attended deceased from 2-5-39, 19, to 2-17-39, 19.

I last saw her alive on 2-17-39, 19. Death is said to have occurred on the date stated above, at 5p m.

The principal cause of death and related causes of importance were as follows:

Streptococcus angina Date of onset 2-5-39

157 C
Other contributory causes of importance:
Congenital malformation of heart
Cerebral arteriosclerosis 2-6-39
Acute dilatation of heart 2-17-39

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19 _____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify _____
(Signed) Urban J. Brant, M. D.

(Address) Springfield Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

M. J. Canaday

Licensed Embalmer No.....

3434

P. O. Address.....

Springfield, 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 this body is not embalmed, above space should be left blank.