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.

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

43400
Do not use this space.

1. PLACE OF DEATH
(a) County GREENE 1 Registration District No. 318
(b) Township 1 Primary Registration District No. 2001 Registered No. 932
(c) City SPRINGFIELD (d) Street No. Burge Hosp 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 360 Lawrence Carroll Rader
(a) Residence, No. Webster Co. St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m.
4. COLOR OR RACE w.
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) June 26 1939
7. AGE YEARS 0 MONTHS 5 DAYS 27 If LESS than 1 day, ...hrs. or ....min.

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) (STATE OR COUNTRY) Webster Co. Mo.

FATHER
13. NAME Ruben Simeon Rader. 0
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Webster Co Missouri. 0

MOTHER
15. MAIDEN NAME Dorthea Rader 0
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Webster Co Missouri

17. INFORMANT (ADDRESS) Mr Ruben Rader Webster Co.
18. BURIAL, CREMATION, OR REMOVAL PLACE Rader Cemetary DATE 12-24 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Rainey Funeral Home Marshfield Mo.
20. FILED 12/23 1939 Chas. A. George M. D. Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-23- 1939

22. I HEREBY CERTIFY, That I attended deceased from 11-20-39, 19.., to 12-23, 1939
I last saw him alive on 12-23-39 Death is said to have occurred on the date stated above, at 9 25 p.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Influenza (primary cause)	11-13-39
Bronchopneumonia	11-15-39
Meningitis influenzal	11-20-39

Other contributory causes of importance: 11 N

Name of operation Date of
What test confirmed diagnosis? Cerebro Spinal fluid 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) [signature], M. D.
(Address) Springfield Mo

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com with the above constitutes grounds for revocation of license.)

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