FILED AUG 23 1940

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

26417
Do not use this space.

1. PLACE OF DEATH
(a) County SALINE 2 Registration District No. 796
(b) Township MARSHALL 6 Primary Registration District No. 3038 Registered No. 115
(c) or City MARSHALL (d) Street No. ..... 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 SHIRLEY MAE RADEY
(a) Residence, No. 700 SOUTH SHARP 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: FEMALE
4. COLOR OR RACE: WHITE
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): SINGLE
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: ←
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) NOV. 26 1935
7. AGE: YEARS 4 MONTHS 7 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) MARSHALL, MO.

FATHER
13. NAME Jess Rader
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) COOPER COUNTY

MOTHER
15. MAIDEN NAME MABLE MARIE GRANDSTAFF
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) LEXINGTON MO.

17. INFORMANT (ADDRESS) JESS RADEY Marshall, Mo.
18. BURIAL, CREMATION, OR REMOVAL PLACE Burial-Herndon, Mo. DATE July 25, 1940
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Don Short Marshall, Mo.
20. FILED 7-24 1940 Mary Kent Dep. Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 23, 1940
22. I HEREBY CERTIFY, That I attended deceased from July 23, 1940, to July 23, 1940
I last saw her alive on SAME DAY, 19..... Death is said to have occurred on the date stated above, at 1:15 P.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Bronchopneumonia	July 19

Other contributory causes of importance:

Name of operation none Date of
What test confirmed diagnosis? auscultation Was there an autopsy?
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) L. E. Harvey, D.O. M.D.
(Address) Marshall, Mo.

(Licensed Embalmer's Statement on Reverse Side)

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

107W

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 8-12-40

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 Donald W. Short, Registered Apprentice No. ..... working under my personal supervision.

Signed Donald W. Short

Licensed Embalmer No. 3757

P. O. Address Marshall

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 26417

Registration District No. 796 — Primary Registration District No. 3038 — Registrar's No. 115

1. PLACE OF DEATH
(a) County: Saline
(b) City or town: Marshall
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community .....

2. USUAL RESIDENCE OF DECEASED:
(a) State ..... (b) County .....
(c) City or town .....
(If outside city or town limits write "RURAL")
(d) Street No. ..... (If rural, give location)
(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME: Shirley Mae Rader
3. (b) If veteran, name war .....
3. (c) Social Security No. .....

4. Sex: F
5. Color or race: W
6. (a) Single, widowed, married, divorced: S
6. (b) Name of husband or wife .....
6. (c) Age of husband, or wife, if alive ..... years
7. Birth date of deceased ..... (Month) (Day) (Year)

8. AGE: Years 4 Months 7 Days 27 If less than one day ..... hr. ..... min.

9. Birthplace ..... (City, town, or county) (State or foreign country)
10. Usual occupation .....
11. Industry or business .....
12. Name .....
13. Birthplace ..... (City, town, or county) (State or foreign country)
14. Maiden name .....
15. Birthplace ..... (City, town, or county) (State or foreign country)
16. (a) Informant .....
(b) Address .....
17. (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (Month) (Day) (Year)
(c) Place: burial or cremation .....
18. (a) Signature of funeral director .....
(b) Address .....
19. (a) ..... (Date received local registrar) (b) ..... (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 23 year 1940 hour ..... minute ..... M.
21. I hereby certify that I attended the deceased from ..... 19..... to ..... 19..... ; that I last saw him alive on ..... 19..... ; and that death occurred on the date and hour stated above.

Immediate cause of death: Bronchopneumonia — Duration
Due to: Acute coryza
Due to: .....
Other conditions: Mild malnutrition
(Include pregnancy within 3 months of death)

Major findings:
Of operations: None
Of autopsy .....

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) .....
(b) Date of occurrence .....
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? ..... (Specify type of place)
While at work? ..... (e) Means of injury .....

23. Signature: R. E. Brown (M. D. or other) DO
Address: Marshall, Mo. Date signed 9-18-40

SUPPLEMENTARY

MOTHER FATHER