

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 4357

1. PLACE OF DEATH:

(a) County Jackson  
 (b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
4410 Holly Street  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether)  
 In this community 40 Years  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
 (c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 4410 Holly Street  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

FILED DEC 11 1940

MEDICAL CERTIFICATION

3. (a) PRINT FULL NAME The Reverend Albert B. Shrader, D.D.

20. DATE OF DEATH: Month November day 14th  
 year 1940 hour 5:50 minute \_\_\_\_\_ P. M.

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. None

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 1934, to 11/14, 1940  
 that I last saw him alive on 11/14, 1940  
 and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

Immediate cause of death Carcinoma of bladder 1939

6. (b) Name of husband or wife Mrs. Harriet L. Shrader 6. (c) Age of husband or wife if alive 84 years

7. Birth date of deceased November 10 1854  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
86 0 4 hr. min.

Due to \_\_\_\_\_ 51  
 Due to \_\_\_\_\_

9. Birthplace Mt. Carroll Illinois  
(City, town, or county) (State or foreign country)

Other conditions Carcinoma sclerotic 1922  
(Include pregnancy within 3 months of death)

10. Usual occupation Pastor Emeritus

11. Industry or business Trinity Lutheran Church, C. K.

PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.  
 Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

12. Name Peter Shrader

13. Birthplace Pennsylvania  
(City, town, or county) (State or foreign country)

14. Maiden name Cordelia Ray

15. Birthplace Ohio  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. G. W. Kent

(b) Address 1014 Greenway Terr

17. (a) Burial (b) Date thereof Nov. 16, 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Moriah Cemetery

18. (a) Signature of funeral director D. H. Peppers

(b) Address 1401 Brush Creek Blvd.

19. (a) 11-15-40 (b) M. M. Browne  
(Date received local registrar) (Registrar's signature)

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) (e) Means of injury

23. Signature W. B. Riddle (M. D. or other) \_\_\_\_\_  
 Address 612 Commercial Bldg Date signed 11/15/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

Dr. Kyle H. Will  
Professional  
1-5  
1/16

**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. 4043

P. O. Address. K. C. M.

**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.