

WED JUL 13 1944
Registration District No. **949**

Primary Registration District No. **1002**

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 **Research Hospital**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **2 days**
(Specify whether years, months or days)

In this community **3 1/2 yrs.**

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. **5924 Grand Avenue**
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country **-----**

3. (a) PRINT FULL NAME **Mr. Frank D Rader**

3. (b) If veteran, name war **WW** 3. (c) Social Security No. **989-24-4975**

4. Sex **Male** 5. Color or Race **White** 6. (a) Single, widowed, married, divorced **M**

6. (b) Name of husband or wife **Ann** 6. (c) Age of husband or wife if alive **57** years

7. Birth date of deceased **March 31 1884**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
59	2	23	hr. min.

9. Birthplace **Egypt** **Kentucky**
(City, town, or county) (State or foreign country)

10. Usual occupation **Lawyer**

11. Industry or business **self**

12. Name **Christopher Rader**

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

14. Maiden name **Armina**
(City, town, or county) (State or foreign country)

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

16. (a) Informant **Mrs Anna Rader**

(b) Address **5924 Grand**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **6-26-43**
(Month) (Day) (Year)

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

18. (a) Signature of funeral director **D. W. Newcomer, Sr.**

(b) Address **1401 Brush Creek Blvd.**

19. (a) **6-27-43** (Date received local registrar) (b) **J. E. Brown** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **24th** year **1943** hour **-----** minute **-----** A. M.

21. I hereby certify that I attended the deceased from **6-23-43** to **6-24-43** and that death occurred on the date and hour stated above.

Immediate cause of death **Acute Myocarditis**
Cardiac Decompensation

Due to **9502**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **No Periton.**

Of autopsy **yes - Myocardial degeneration**

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? **-----**

While at work? **-----** (Specify type of place) (e) Means of injury **-----**

23. Signature **J. E. Brown** (M. D. or other) Address **-----** Date signed **6/25/43**

Duration **30 days**

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

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

MOTHER FATHER

10/60
2-4

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 Emile M. Colburn
Licensed Embalmer No. 3506
P. O. Address RC 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, fact should be so stated above.