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FILED MAR 14 1944

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

8546

State File No.

Registration District No. 340

Primary Registration District No. 6152

Registrar's No. 9

1. PLACE OF DEATH:

(a) County Stoddard

(b) City or town Rural Stoddard
(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)

3. (a) PRINT FULL NAME Sarah Francis Schrader

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife — 6. (c) Age of husband or wife if alive 3 years (Day) (Year)

7. Birth date of deceased April 3 1867
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

76 10 16 hr. min.

9. Birthplace Hamilton Co., Ill.
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business —

12. Name Otto Schrader

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

14. Maiden name Adina K. Hanson

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

16. (a) Informant Sam Schrader

(b) Address R#1 Bernie Mo

17. (a) Burial (b) Date thereof Feb. 20, 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Poplar Cemetery

18. (a) Signature of funeral director Buncan Funeral Home

(b) Address Bernie, Mo.

19. (a) 2-29-44 (b) Cardie Miller
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County Stoddard

(c) City or town Rural
(If outside city or town limits, write "RURAL")

(d) Street No. — (If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month FEB. day 19
year 1944 hour 3 minute 45 P.M.

21. I hereby certify that I attended the deceased from 12-29- 1943 to 2-18- 1944
that I last saw her alive on 2-14- 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Bowel Duration 2 months

Due to —

Due to —

Other conditions —
(Include pregnancy within 3 months of death) H62

Major findings:
Of operations —

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? —

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

23. Signature Dewey C. Ryan (M. D. or other) —

Address Bernie Mo Date signed 2-21-44

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

MOTHER FATHER

1133

RECEIVED

District Health Office No. 2,

District File Number 344-461

Date Filed 3-9-44

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 comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.