

S. No. 2
DM-5-43
v. 5-17-39
P I X36571

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
#44019
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **26048**
Registrar's No. **7770**

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:
(a) County _____
(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis City Hospital - Max C. Starkloff Memorial
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1mo 19 days
(Specify whether _____)
In this community 67 years
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 000
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 3709 N. Broadway
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME GEORGE RADER
3. (b) If veteran, name war none 3. (c) Social Security No. none
4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced Separated
6. (b) Name of husband or wife Mrs. Olive Rader 6. (c) Age of husband or wife if alive 59 years
7. Birth date of deceased August 30th., 1883
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept. day 3rd
year 1945 hour 3:05 minute P. M.
21. I hereby certify that I attended the deceased from 7/14/45
_____ 19____ to 9/3/45 19____
that I last saw him alive on 9/3/45 19____
and that death occurred on the date and hour stated above.

8. AGE: Years 62 Months 0 Days 3 If less than one day
hr. _____ min. _____

Immediate cause of death Adenocarcinoma of Stomach
Due to _____
Due to _____
Other conditions 46
(Include pregnancy within 3 months of death)

9. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)
10. Usual occupation Porter

11. Industry or business _____
12. Name William Rader
13. Birthplace unknown 9
(City, town, or county) (State or foreign country)
14. Maiden name unknown
15. Birthplace unknown 9
(City, town, or county) (State or foreign country)

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

16. (a) Informant Mr. Carl Rader
(b) Address 3709 N. Broadway
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-7-45
(Month) (Day) (Year)
(c) Place: burial or cremation Friedens Cemetery
18. (a) Signature of funeral director Hy. Leidner U. Co.
(b) Address 2223 St. Louis Ave.
19. (a) SEP 5 1945 (b) _____
(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?
While at work? _____ (Specify type of place) (Means of injury)
23. Signature Herbert C. Gutz (M. D. or other) _____
Address 1515 Lafayette signed 9/4/45

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

MOTHER, FATHER

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 *John P. Buchholz*
Licensed Embalmer No. *1674*
P. O. Address *2223 St. Louis Ave*

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.