

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

5-43
17-39
X36671

FILED JAN 25 1946

Registration District No. 5575 Primary Registration District No. 5575

1. PLACE OF DEATH

(a) County Jackson

(b) City or town Martin City RURAL WASHINGTON
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution WORNALL ROAD BRIDGE NORTH OF 103RD ST
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3
(Specify whether years, months or days)

In this community 14 YEARS
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

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

(d) Street No. P.O. Box 65
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME ALBERT W. RADER, SR.

3. (b) If veteran, name war WORLD WART

3. (c) Social Security No. 510-07-8010

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 5
year 1946 hour 7:00 minute a 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.

4. Sex Male 5. Color or race white

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

6. (b) Name of husband or wife MRS. ADA B. RADER

6. (c) Age of husband or wife if alive 45 years

7. Birth date of deceased JANUARY 15 1896
(Month) (Day) (Year)

Immediate cause of death Skull Fracture

Due to Multiple Fractures of Right Shoulder, chest + leg

Due to Auto Traumatism

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

49 11 21 hr. min.

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: 'Of operations' _____

Of autopsy History + Examination

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

9. Birthplace MONONGAHELA PENNSYLVANIA
(City, town, or county) (State or foreign country)

10. Usual occupation APARTMENT UNIT DEALER

11. Industry or business RADER REALTY CO. - DWIGHT BLDG

12. Name JOSEPH F. RADER

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

14. Maiden name AMELIA UMBANON

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

16. (a) Informant Mrs. Ada B. Rader

(b) Address Martin City, Missouri

17. (a) BURIAL (b) Date thereof JAN 9 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MT MORIAN CEM - K @ MD

18. (a) Signature of funeral director J. J. Newcomer, D.D.O.

(b) Address 1401 Birch Creek Blvd.

19. (a) Jan 10 1946 (b) Dr. Anne G. Hedges
(to received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Don't know 48

(b) Date of occurrence 1-5-46

(c) Where did injury occur? 103 + Wornall Jackson mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Public place
(Specify type of place)

While at work? no (e) Means of injury automobile

23. Signature Janell Walker (M. D. or other) _____
Address 1424 24th St Date signed 1-5-46

FEB 1 1946

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..... *Jack W. Raybourne*
Licensed Embalmer No..... *1715*

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.

Registration District No. 154 Primary Registration District No. 5575

1. PLACE OF DEATH:
 (a) County Jackson
 (b) City or town Rural Washington
(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)
 In this community _____
years, months or days

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

3. (a) PRINT FULL NAME Albert W. Pader Sr
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____
 7. Birth date of deceased Jan 15 1948
(Month) (Day) (Year)

8. AGE: Years 49 Months _____ Days _____
(Unless than one day)
 hr. _____ min. _____

9. Birthplace Presn
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
 { 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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation _____

13. (a) Signature of funeral director _____
 (b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month _____ year 1948 hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____ 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 Skull Fracture
 Duration _____

Due to Multiple Fractures of Right shoulder, Chest & Legs
 Due to Auto Traumatism

Other conditions Auto struck fixed object-(Bridge)
(Include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 Of autopsy no-History & Inspection
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) Don't Know
 (b) Date of occurrence 1-5-48
 (c) Where did injury occur? 103 & Wornall Jackson Mo
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
Public Place
 While at work? no (Specify type of place) Automobile
(e) Means of injury
 23. Signature James C Walker, Coroner (M. D. or other) _____
 Address 1424 Professional Bldg Date signed 1-5-48

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

SUPPLEMENTARY

2966