

FILED FEB 25 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 4729

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

BIRTH NO. _____ REG. DIST. NO. 140 PRIMARY REG. DIST. NO. 4229 Registrar's No. 3

1. PLACE OF DEATH a. COUNTY <u>Howard</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN <u>New Franklin</u>		c. CITY OR TOWN <u>New Franklin Mo.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>N. Mo. Ave. New Franklin</u>		d. STREET ADDRESS (If rural, give location) <u>N. Mo. Ave.</u>	
3. NAME OF DECEASED a. (First) <u>CARI</u> b. (Middle) <u>MARION</u> c. (Last) <u>SHRADER</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>2-16-1949</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Mar. 18-1882</u>
9. AGE (In years last birthday) <u>66</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>	11. BIRTHPLACE (State or foreign country) <u>Mo. Mo. Mo.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Charles Marion Shrader</u>	
13b. MOTHER'S MAIDEN NAME <u>Maurilia Schultz</u>		14. NAME OF HUSBAND OR WIFE <u>Single</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16. SOCIAL SECURITY NO. <u>-</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Julian S. Lee</u> ADDRESS <u>New Franklin Mo.</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary occlusion</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>arteriosclerosis</u> DUE TO (c) <u>unknown</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>none</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21. ACCIDENT SUICIDE HOMICIDE (Specify) _____	
21a. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>at</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? _____		22. I hereby certify that I attended the deceased from <u>Feb 16, 1949</u> , to <u>Feb 16, 1949</u> that I last saw the deceased alive on <u>Feb 16, 1949</u> , and that death occurred at <u>12:00 p.m.</u> , from the causes and on the date stated above.	
23a. SIGNATURE <u>G. L. Chamberlain</u> (Degree or title) _____		23b. ADDRESS <u>New Franklin Mo.</u>	
23c. DATE SIGNED <u>2-17-49</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
24b. DATE <u>2/17/49</u>		24c. NAME OF SEMETERY OR CREMATORY <u>mt. Pleasant</u>	
24d. LOCATION (City, town, or county) (State) <u>New Franklin Mo.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. D. Blum</u> ADDRESS <u>New Franklin</u>	
DATE REC'D BY LOCAL REG. <u>2/18/49</u>		REGISTRAR'S SIGNATURE <u>W. D. Blum</u> 404	

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 2-24-49

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.....

..... working under my personal supervision.

Student Embalmer No.

Signed [Signature]

Signed.....
Student Embalmer

Licensed Embalmer No. 3515

P. O. Address New Franklin Me

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.