

FILED FEB 27 1950

STANDARD CERTIFICATE OF DEATH

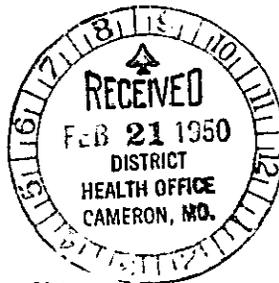
State File No. 5349

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

BIRTH NO. _____ REG. DIST. NO. 187 PRIMARY REG. DIST. NO. 3040 Registrar's No. 21

1. PLACE OF DEATH a. COUNTY LIVINGSTON			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MO. b. COUNTY DAVIESS		
b. CITY (If outside corporate limits, write RURAL and give township) CHILlicothe		c. LENGTH OF STAY (In this place) 3 WEEKS	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN JAMESPORT 0310		
d. FULL NAME OF HOSPITAL OR INSTITUTION 60 CHERRY ST.			d. STREET ADDRESS (If rural, give location) MISSOURI		
3. NAME OF DECEASED (Type or Print) a. (First) WILLIAM		b. (Middle) HENRY	c. (Last) RADER	4. DATE OF DEATH (Month) (Day) (Year) FEB. 1 1950	
5. SEX M	6. COLOR OR RACE WH-	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) ✓	8. DATE OF BIRTH DEC. 13 1864	9. AGE (In years last birthday) 85	If UNDER 1 YEAR Months 11 Days 18
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING	11. BIRTHPLACE (State or foreign country) NEAR LOCKSPRINGS, MO.		12. CITIZEN OF WHAT COUNTRY? A.M.
13a. FATHER'S NAME JOHN RADER		13b. MOTHER'S MAIDEN NAME MARGARET STILES	14. NAME OF HUSBAND OR WIFE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or date of service) ✓		16. SOCIAL SECURITY NO. ✓	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mr. H. L. Schewe		
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, asthma, etc. It means the disease, injury, or complication which caused death.			MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) cerebral hemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) hypertension DUE TO (c) arteriosclerosis.		INTERVAL BETWEEN ONSET AND DEATH 1 wk.
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	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 1-27 , 19 50 , to Feb 1 , 19 50 , that I last saw the deceased alive on Jan 31 , 19 50 , and that death occurred at 6:00 A.M. , from the causes and on the date stated above.					
23a. SIGNATURE Joseph F. Gal		23b. ADDRESS Chillicothe Mo.	23c. DATE SIGNED 2-3-50.		
24a. BURIAL (Specify)	24b. DATE 2-3-50	24c. NAME OF CEMETERY OR CREMATORY CLEAR CREEK	24d. LOCATION (City, town, or county) (State) Davies Mo		
DATE REC'D BY LOCAL REG. 2-3-50	REGISTRAR'S SIGNATURE Francis B. Neal	25. FUNERAL DIRECTOR'S SIGNATURE John R. ...	ADDRESS Jamesport Mo.		



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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Rollin L. Richardson

Licensed Embalmer No. 4715

P. O. Address Jamestown, 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.