

FILED NOV 10 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33553

State File No.

4621

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. <u>4621</u>	
1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		c. LENGTH OF STAY (in this place) <u>1 Day</u>		c. CITY OR TOWN <u>R.R. Independence</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Joseph Hospital</u>				STREET ADDRESS (If rural, give location) <u>54th & Noland Road</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Mary</u>		b. (Middle) <u>Myrtle</u>		c. (Last) <u>Srader</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Oct 26 1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov 29 1889</u>		9. AGE (In years last birthday) <u>65</u>	if UNDER 1 YEAR: Months _____ Days _____	if UNDER 60 HRS: Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Homemaking</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Jackson County, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13a. FATHER'S NAME <u>David D. Faulconer</u>		13b. MOTHER'S MAIDEN NAME <u>Martha F. Suttles</u>		14. NAME OF HUSBAND OR WIFE <u>Homer D. Srader</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) <input checked="" type="checkbox"/> (If yes, give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>497-26-2388</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Homer D. Srader - 54th & Noland Rd.</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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* <u>Cranial Metastases from Carcinoma of (Breast) (old)</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>170x</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) (Min.)		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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>H. Frank Holman M.D.</u>				23b. ADDRESS <u>St. Joseph Hospital</u>		23c. DATE SIGNED <u>10-27-55</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Oct 29 1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Floral Hills</u>		24d. LOCATION (City, town, or county) (State) <u>Kansas City Missouri</u>		
DATE REC'D BY LOCAL REG. <u>10-27-55</u>		REGISTRAR'S SIGNATURE <u>Neva Marshall</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>FLORAL HILLS MEMORIAL CHAPELS, INC., K.C.MO</u>			

(Licensed Embalmers' Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD
H. Frank Holman

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.....
Signature of Student Embalmer

Signed 

Licensed Embalmer No. 485

P. O. Address 710

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.