

Health,  
Welfare  
Public  
Service

FILED AUG 26 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

27823

STATE NUMBER

Registration District No. 75 Primary Registration District No. 3015 Registrar's No. 81

300  
-57 D

1. PLACE OF DEATH a. COUNTY <b>Clinton</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Daviess</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Cameron</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Gallatin</b> <sup>0310</sup>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Cameron Community Hosp.</b>		Length of stay in 1b <b>Few Minutes</b>	d. STREET ADDRESS <b>---</b> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Leta</b> Middle <b>Frances</b> Last <b>Rader</b>			4. DATE OF DEATH Month <b>August</b> Day <b>10</b> Year <b>1957</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 8, 1938</b>
9. AGE (In years last birthday) <b>19</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>General Office Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Insurance Co.</b>	11. BIRTHPLACE (City and state or country) <b>Daviess Co., Mo.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13a. FATHER'S NAME <b>Elmer Rader</b>	
13b. MOTHER'S MAIDEN NAME <b>Oleta Drummond</b>		14. NAME OF HUSBAND OR WIFE <b>---</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>486-40-7332</b>	
17. INFORMANT <b>Elmer Rader, Gallatin, Mo.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple Skull fractures</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 hours</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Multiple fractures of left arm</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>Auto mobile overturned</b>	
20c. TIME OF INJURY <b>8:30 p.m. 8-10-57</b>			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>3 mi East of Jasperton Highway</b>	
20f. CITY, TOWN, OR LOCATION <b>04 County, Mo.</b>		STATE	
21. I attended the deceased from <b>8:35 P.M. - Aug 10 57</b> to <b>9:45 - 1957</b> and last saw her/him alive on <b>Aug 10 - 57</b> Death occurred at <b>9:45 P.M. - Aug 10 - 57</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>J.B. Bailey DO 2</b>		22b. ADDRESS <b>Jasperton Mo</b>	
22c. DATE SIGNED <b>8-11-57</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>8-12-1957</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Prarie Valley Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Gallatin, Mo.</b>	
24. FUNERAL DIRECTOR <b>Hope Funeral Home, Gallatin, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>8-18-57</b>	
26. REGISTRAR'S SIGNATURE <b>Francis W Crawford</b>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

AUG 27 1951

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 *L. O. Richerson*

Licensed Embalmer No. *3302*  
P. O. Address *Galatun*

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.