DURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS DEC 2 1959

59-040906

STATE FILE NUMBER

MENDED

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 274

1. PLACE OF DEATH
a. COUNTY Shillicothe Hospital
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Shillicothe Mo — Length of stay in Ib 26 days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Shillicothe Hospital — Inside Limits Yes ☑ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo b. COUNTY Livingston
c. CITY OR TOWN Chillicothe — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS 903 Broadway (If outside, give location) — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First WALTER Middle X Last RADER

4. DATE OF DEATH Month 11 Day 26 Year 59

5. SEX M
6. COLOR OR RACE white
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH Aug 5-1870
9. AGE (last birthday) 89
IF UNDER 1 YEAR Months Days — IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer
10b. KIND OF BUSINESS OR INDUSTRY Retired Farmer
11. BIRTHPLACE (City and state or country) Caylow Mo
12. CITIZEN OF WHAT COUNTRY U.S

13a. FATHER'S NAME John Rader
13b. MOTHER'S MAIDEN NAME Emma Stiles
14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. —
17. INFORMANT Mrs A. G. Whitley Address Jamesport Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH 3 Days

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Arterio hypertension — 15 days
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
Coronary occlusion - Renal ischemia

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from October 13 1959, to November 26 1959 and last saw him alive on November 26 1959
Death occurred at 11/26/59 10:05 P.m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Sam D. Matthews (Degree or title) D.O.
22b. ADDRESS Chillicothe, Missouri
22c. DATE SIGNED 11/27/59

23a. BURIAL, ~~CREMATION~~, REMOVAL (Specify) Burial
23b. DATE Nov-29-59
23c. NAME OF CEMETERY OR CREMATORY Masonic Cem
23d. LOCATION (City, town, or county) Jamesport (State) Mo

24. FUNERAL DIRECTOR C. L. Robertson
ADDRESS Jamesport Mo
25. DATE RECD. BY LOCAL REG. 11/27/59
26. REGISTRAR'S SIGNATURE Frances B Neal

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF DOCUMENT

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 O. L. Roberson

Licensed Embalmer No. 3244

P. O. Address Jamesport m

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl 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.