

U.S. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 4 5 8 4 8

FILED VS DEC 3 0 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **211499** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 1 Day		c. CITY OR TOWN St. Louis County		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Missouri Baptist Hosp.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 10107 Green Valley Dr.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elenora Middle K. Last Rader			4. DATE OF DEATH Month 12 Day 9 Year 59				
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 12-16-04	9. AGE (last birthday) 54	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) At Home			10b. KIND OF BUSINESS OR INDUSTRY House Wife		11. BIRTHPLACE (City and state or country) West Point, Ill.	12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Theodore Westermann			13b. MOTHER'S MAIDEN NAME Caroline Freytag		14. NAME OF HUSBAND OR WIFE Howard H. Rader		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. None	17. INFORMANT Address Howard H. Rader 10107 Green Valley Dr.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain tumor. (Malignant Glioblastoma)						INTERVAL BETWEEN ONSET AND DEATH 1 year	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____						193.0	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input 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.)				
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. 12:45	Month, Day, Year 12-9-59						
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 Oct. 1959 to Dec. 9, 1959 and last saw her alive on Dec. 9, 1959 Death occurred at 8:10 PM on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) James O. Jolley, M.D.			22b. ADDRESS 6500 Chippewa		22c. DATE SIGNED 12-11-59		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 12-12-59	23c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri			
24. FUNERAL DIRECTOR ADDRESS White-Mullen 118 N. Florissant Rd. Ferg.			25. DATE RECD. BY LOCAL REG. DEC 11 1959	26. REGISTRAR'S SIGNATURE Loard Smith. M.D.			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

5.630

Dr. Schaefer
9 11 44
L. G. Chaffin
72 1 1

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Richard H. Johnson

Licensed Embalmer No. 3395

P. O. Address St Louis 3

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