WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Ray

Township Richmond Registration District No. 744 File No. 6546

or Village

Primary Registration District No. 5771B Registered No. 132

or City (No. St., Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Geo Rader

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

DATE OF BIRTH: April 24, 1839 (Month) (Day) (Year)

AGE: 73 yrs. 10 mos. 4 ds. If LESS than 1 day, hrs. or min.?

OCCUPATION (a) Trade, profession, or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): 1-02

BIRTHPLACE (City or town, State or foreign country): Rockingham Co Va

PARENTS

NAME OF FATHER: Anthony Rader

BIRTHPLACE OF FATHER (City or town, State or foreign country): Rockingham Co Va

MAIDEN NAME OF MOTHER: Elizabeth Nickels

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Rockingham Co Va

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Bud Rader

(ADDRESS) Richmond Mo RFD

Filed Feby 26 1913. Geo W Hunt Depty REGISTRAR

2 **MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH: Feb 25, 1913 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 20, 1913, to Feb 24, 1913, that I last saw him alive on Feb 24, 1913, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Blood Poisoning

Gangrene of feet

988

31

(Duration) yrs. mos. 5 ds.

Contributory (SECONDARY) none

(Duration) yrs. mos. ds.

(Signed) R L Hamilton, M. D.

Feb 25, 1913 (Address) Richmond

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL: Hickory Grove

DATE OF BURIAL: Feb 26, 1913

UNDERTAKER: C O Marsar

ADDRESS: Hardin Mo

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PLACE OF DEATH

County ____________

Township ____________ Registration District No. ____________ File No. ____________
or
Village ____________ Primary Registration District No. ____________ Registered No. ____________
or
City ____________ (NO. ____________, ____________ St.; ____________ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME ____________

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH
____________ (Month) ____________ (Day), 1____________ (Year)

AGE ____________ yrs. ____________ mos. ____________ ds. — If LESS than 1 day, ____ hrs, or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work ____________
(b) General nature of industry, business, or establishment in which employed (or employer) ____________

BIRTHPLACE (City or town, State or foreign country) ____________

PARENTS
NAME OF FATHER ____________
BIRTHPLACE OF FATHER (City or town, State or foreign country) ____________
MAIDEN NAME OF MOTHER ____________
BIRTHPLACE OF MOTHER (City or town, State or foreign country) ____________

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) ____________

(ADDRESS) ____________

Filed ____________, 191____, ____________ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH
____________ (Month) ____________ (Day), 191____ (Year)

I HEREBY CERTIFY, that I attended deceased from ____________, 191____, to ____________, 191____,

that I last saw h____ alive on ____________, 191____,

and that death occurred, on the date stated above, at ____________ m.

The CAUSE OF DEATH* was as follows:

____

____________ (Duration) ____ yrs. ____ mos. ____ ds.

Contributory ____________
(SECONDARY)
____________ (Duration) ____ yrs. ____ mos. ____ ds.

(Signed) ____________ M. D.

____________, 191____ (Address) ____________

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death? ____________

Former or usual residence ____________

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ____________, 191____
UNDERTAKER	ADDRESS