

FILED MAY 12 1944

Registration District No. 297

Primary Registration District No. 3057

Registrar's No. 24

1. PLACE OF DEATH:

(a) County Joseph P. Rader Ray
(b) City or town Richmond, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
206 West North Main St. /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 72 Years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Ray 89
(c) City or town Richmond (If outside city or town limits, write "RURAL")
(d) Street No. 206 W. N. Main St. / (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Joseph F. Rader

3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex Male 0 5. Color or race White 6. (a) Single, widowed, married, divorced Widow 1

6. (b) Name of husband or wife Olive Speer 6. (c) Age of husband or wife if alive Deceased years

7. Birth date of deceased Dec. 29, 1864
(Month) (Day) (Year)

8. AGE: Years 79 Months 3 Days 9 If less than one day hr. _____ min. _____

9. Birthplace Unknown (City, town, or county) Vir. / (State or foreign country)

10. Usual occupation Carpenter

11. Industry or business George Rader

12. Name George Rader

13. Birthplace Unknown (City, town, or county) Vir. / (State or foreign country)

14. Maiden name Kathrine Mason

15. Birthplace Unknown (City, town, or county) Vir. / (State or foreign country)

16. (a) Informant Mrs Daniel Lierman
(b) Address Richmond, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof April 9 1944 (Month) (Day) (Year)
(c) Place: burial or cremation Hickory Grove, Mo.

18. (a) Signature of funeral director [Signature]
(b) Address Richmond, Mo.

19. (a) 4/13 44 (Date received local registrar) (b) [Signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 7
year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from 2-13-
1944 to 2-25- 1944
that I last saw him alive on 2-25- 1944
and that death occurred on the date and hour stated above.

Immediate cause of death
Chronic Myocarditis
arterio sclerosis

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings:
Of operations _____
Of autopsy _____

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? _____ (Specify type of place) _____ (e) Means of injury _____

23. Signature [Signature] (M. D. or other) MD
Address Richmond, Mo Date signed 4-9-44

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 5-11-47

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, ~~###~~
Registered Apprentice No. _____
working under my personal supervision.

Signed _____
Licensed Embalmer No. 2073
P. O. Address Richmond, Mo.

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 this body is not embalmed, fact should be so stated above.