

**FILED APR 21 1947**

Registration District No. **29**

Primary Registration District No. **3057**

Registrar's No. **29**

**1. PLACE OF DEATH:**

(a) County **Ray**  
 (b) City or town **Richmond**  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
**206 W. North Main**  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution. (Specify whether  
 In this community **74 yrs.** years, months or days)

3. (a) PRINT FULL NAME **MINNIE C. RADER**  
 3. (b) If veteran, name war **None**  
 3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **W**  
 6. (a) Single, widowed, married, divorced **wid**  
 6. (b) Name of husband or wife **John M. Rader**  
 6. (c) Age of husband or wife if alive **None** years  
 6. Birth date of deceased **Oct 4 1872**  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**74 5 10** hr. min.

9. Birthplace **Lone Jack Mo.**  
 (City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business

MOTHER FATHER  
 12. Name **George Rader** 9  
 13. Birthplace **Richmond** 9  
 (City, town, or county) (State or foreign country)  
 14. Maiden name **Helen Sawyer**  
 15. Birthplace **Richmond** 9  
 (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Helen Freeman**  
 (b) Address **Richmond, Mo.**

17. (a) **Burial** (b) Date thereof **3/17/47**  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Widow Home Care**

18. (a) Signature of funeral director **Walter H. 7H**  
 (b) Address **Richmond, Mo.**

19. (a) **March 18, 1947** (b) **Malcol Goshorn**  
 (Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State **Missouri** (b) County **Ray** 89  
 (c) City or town **Richmond** 1  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. **206 W. N. Main** 1  
 (If rural, give location)  
 (e) Citizen of foreign country? **0** (Yes or No)  
 If yes, name country

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month **March** day **14**  
 year **1947** hour **3:30 P.** minute **M.**

21. I hereby certify that I attended the deceased from **14 Mar 1947** to **14 Mar 1947**  
 that I last saw her alive on **14 Mar 1947**  
 and that death occurred on the date and hour stated above.

Immediate cause of death **Supostatic Pneumonia** Duration **1 day**

Due to **Pulmonary Edema** **2 days**

Due to **Cardiac Dilatation** **2 days**  
**Myocarditis, Chronic**

Other conditions **Hypertrophic Arteriosclerosis** **10 yrs.**  
 (Include pregnancy within 6 months of death)

Major findings: **930**

Of operations  
 Of autopsy  
**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) (a) Means of injury **0**

23. Signature **J. Lockell M.D.** D. or other  
 Address **Richmond, Mo.** Date signed **17 Mar 47**

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

**RECEIVED**

**District Health Officer No. 8,**

District File Number .....

Date Filed 4-18-47

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**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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed..... *George Hill*.....

Licensed Embalmer No. 4066.....

P. O. Address Richmond, Va......

**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.**