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7-39
X23159

Registration District No. 99

Primary Registration District No. 1602

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 2637 Park
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community 33 years, months or days

3. (a) PRINT FULL NAME John Martin Strader

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife William B Strader

6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased: Aug 20 1864
(Month) (Day) (Year)

8. AGE: Years 76 Months 7 Days 10 If less than one day hr. _____ min. _____

9. Birthplace New York
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Fireman

11. Industry or business R.C. Terminal Ry Co.

MOTHER FATHER

12. Name Milford Strader

13. Birthplace N.Y.
(City, town, or county) (State or foreign country)

14. Maiden name Mary Ann

15. Birthplace New York
(City, town, or county) (State or foreign country)

16. (a) Informant William B. Strader

(b) Address 2637 Park

17. (a) Burial (b) Date thereof Apr - 1 - 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Salama - Conn

18. (a) Signature of funeral director Mr C R Foster

(b) Address 918 Brooklyn R.C. Mo

19. (a) Apr 21 1941 (b) M. M. Crow
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 48

(a) State Missouri (b) County Jackson

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 2637 Park (If rural, give location)

(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar - day 30
year 1941 hour 3 minute 25 a M.

21. I hereby certify that I attended the deceased from Nov - 10 - 1940
_____, 19____, to Mar 20, 1941
that I last saw h u alive on Mar 20 - 41, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Coma

Due to Acute Nephritis

Due to Myocardial Infarction

Other conditions (Include pregnancy within 3 months of death)

Major findings: no Of operations no Of autopsy no

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 D

23. Signature Ernest W. Cavaness (M. D. or other) Mo
Address KANSAS CITY, MO Date signed 3/1

Dr. Curran

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 *me*
....., Registered Apprentice No.
working under my personal supervision.

Signed *J. Clair Sheppard*
Licensed Embalmer No. *4139*
P. O. Address *K. E. Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

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

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No.

Registration District No.

Primary Registration District No.

Registrar's No. **1275**

1. PLACE OF DEATH:

(a) County.....
(b) City or town.....
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
2637 Park
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... (Specify whether
In this community..... years, months or days)

3. (a) PRINT FULL NAME.....

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

4. Sex..... 5. Color or race..... 6. (a) Single, widowed, married, divorced.....

6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... years

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
76 hr. min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) **3/31/41** (b) **M. M. Brown** (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
(c) City or town..... (If outside city or town limits write "RURAL")
(d) Street No..... (If rural, give location)
(e) If foreign born, how long in U. S. A.?..... years.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month **March** day **30th** year **1941** hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19..... to..... 19..... that I last saw h..... alive on..... and that death occurred on the date and hour stated above.

Immediate cause of death..... **Uremic Coma**

Due to **Acute nephritis** **12/18**

Due to **Myocardial degeneration**
Chronic nephritis

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) Means of injury.....

23. Signature **Ernest W. Cavaness** (M. D. or other).....

Address..... **Ernest W. Cavaness, M. D.** Date signed.....

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

SUPPLEMENTAL COPY

S-9866

1941