

FILED JAN 28 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 285

BIRTH NO. 78637-49 REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 83

1. PLACE OF DEATH a. COUNTY Buchanan			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Kansas b. COUNTY Doniphan		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph			c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Jelwood		
d. FULL NAME OF HOSPITAL OR INSTITUTION Missouri Methodist Hosp			d. STREET ADDRESS (If rural, give location) MissouElwoodthodist Hospital		

3. NAME OF DECEASED (Type or Print)	a. (First) SHARON	b. (Middle) ANN	c. (Last) RADER	4. DATE OF DEATH (Month) (Day) (Year)	1 22 1950
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH 12-28-1949	9. AGE (In years last birthday) 25 days	IF UNDER 1 YEAR Months Days	IF UNDER 2 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) St. Joseph, Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Waldean Rader	13b. MOTHER'S MAIDEN NAME Anna Marie Gegg	14. NAME OF HUSBAND OR WIFE None
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Waldean Rader, Elwood, Kansas
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematurity		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c)		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		771X

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from Dec 28, 1949, to Jan 22, 1950, that I last saw the deceased alive on Jan 22, 1950, and that death occurred at 2:30P m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) H. H. Johnson MD J	23b. ADDRESS St. Joseph Mo.	23c. DATE SIGNED 1-24-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 1-24-1950	24c. NAME OF CEMETERY OR CREMATORY Mt. Olive	24d. LOCATION (City, town, or county) (State) Troy, Kansas
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DATE REC'D BY LOCAL REG. Jan 26, 1950	REGISTRAR'S SIGNATURE E. B. Jenkins 382	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Joseph, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 _____

Allin C. Bazar

Student Embalmer No. *342*

working under my personal supervision.

Student *Allin C. Bazar*
Student Embalmer

Signed

John E. Rupp

Licensed Embalmer No. *3986*

P. O. Address *St. Joseph, 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.