

FILED JUL 6 - 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **20882**

BIRTH NO. _____ REG. DIST. NO. **751** PRIMARY REG. DIST. NO. **4370** Registrar's No. **153**

740
4

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

1. PLACE OF DEATH a. COUNTY Nodaway		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Iowa b. COUNTY Page	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Clearmont		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Clarinda	
c. LENGTH OF STAY (in this place) 1yr. 6Mo.		8140	
d. FULL NAME OF HOSPITAL OR INSTITUTION Wallin Nursing Home		d. STREET ADDRESS (If rural, give location) 202 1/2 E. Washington	

3. NAME OF DECEASED (Type or Print) a. (First) ZELMA	b. (Middle) LETHA	c. (Last) RADKE	4. DATE OF DEATH (Month) (Day) (Year) May 22, 1951
--	--------------------------	------------------------	--

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Mar. 13, 1897	9. AGE (In years last birthday) 54	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 1 MIN. Hours	Min.
----------------------	-------------------------------	---	---------------------------------------	---	------------------------	-----------------------	-----------------------	------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) New Market, Iowa.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
--	-----------------------------------	--	--

13a. FATHER'S NAME Samuel Reynolds	13b. MOTHER'S MAIDEN NAME Mary Katherine Kraut	14. NAME OF HUSBAND OR WIFE Walter Radke
---	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Deland Radke - New Market	ADDRESS New Market
--	-------------------------------------	--	---------------------------

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, asthenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial failure		INTERVAL BETWEEN ONSET AND DEATH 48 hrs
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Coronary insufficiency, Arricular fibrillation, left		unknown
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not reflexed to the immediate cause of death. to chronic long standing atherosclerosis to right heart strain due to chronic long standing atherosclerosis		several

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. PLACE OF OPERATION? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
------------------------	----------------------------------	---

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) -4201
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
--	--	----------------------------

22. I hereby certify that I attended the deceased from **Mar 11, 1950**, to **May 21, 1951**, that I last saw the deceased alive on **May 21, 1951**, and that death occurred at **1:55P m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Harold Ford MD	23b. ADDRESS Clarinda, Mo.	23c. DATE SIGNED Jan 19 51
--	-----------------------------------	-----------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE May 22, 1951	24c. NAME OF CEMETERY OR CREMATORY Old Memory	24d. LOCATION (City, town, or county) (State) New Market, Iowa.
--	-------------------------------	--	--

DATE REC'D BY LOCAL REG. 6-30-51	REGISTRAR'S SIGNATURE Bess Holt 229	25. FUNERAL DIRECTOR'S SIGNATURE Soren Davison	ADDRESS Clarinda, Iowa.
---	---	---	--------------------------------



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 _____

Student Embalmer No. _____

working under my personal supervision.

Body was taken to Clarinda Ia. for embalming.

Student
Student Embalmer

Signed Loren Davison

Iowa Licensed Embalmer No. 3148

P. O. Address Clarinda, Iowa.

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.