

diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.  
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED AUG 27 1957

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

30666

STATE FILE NUMBER

Registration District No. 379 Primary Registration District No. 1195 Registrar's No. 37

1. PLACE OF DEATH a. COUNTY <b>Wright</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Wright</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Mountain Grove Township</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <b>Mountain Grove Twp</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>R.F.D. # 2</b>			Length of stay in 1b <b>65 years</b>	d. STREET ADDRESS (If outside, give location) <b>R.F.D. # 2</b>			Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Flora Rader</b>				4. DATE OF DEATH Month <b>August</b> Day <b>9</b> Year <b>1957</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 17, 1869</b>		9. AGE (In years last birthday) <b>88</b>	IF UNDER 1 YEAR Months <b>8</b> Days <b>22</b> Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	11. BIRTHPLACE (City and state or country) <b>Mount Vernon, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert Key</b>				14. MOTHER'S MAIDEN NAME <b>Addie Ward</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT Address <b>Robert Rader Mountain Grove, Missouri</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Atherosclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						DUE TO (b) _____ DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b>	
20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from <b>10-12-1955</b> to <b>8-9-57</b> and last saw her alive on <b>8-9-57</b> Death occurred at <b>10:45 P.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>[Signature] M.D.</b>				22b. ADDRESS <b>[Signature]</b>		22c. DATE SIGNED <b>8-10-57</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>August 12, 1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Thomas Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Wright County Missouri</b>		
24. FUNERAL DIRECTOR <b>Barber Funeral Home - Mtn. Grove, Mo</b>				ADDRESS	25. DATE RECD. BY LOCAL REG. <b>8-15-57</b>	26. REGISTRAR'S SIGNATURE <b>A.B. Ames</b>	

Name of Deceased: \_\_\_\_\_  
 Date of Death: \_\_\_\_\_  
 Place of Death: \_\_\_\_\_  
 Name of Embalmer: \_\_\_\_\_  
 License No.: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_  
 Date of Embalming: \_\_\_\_\_  
 Name of Undertaker: \_\_\_\_\_  
 License No.: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_

RECEIVED 8-20-59  
 WRIGHT CO.

**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.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed George Stapp  
 Licensed Embalmer No. 71  
 P. O. Address Wright Co. Pa.

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

**If embalmed by a STUDENT, he also shall sign in his OWN handwriting.**

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

Order for relief - 1959-10-15