

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-016403

STATE FILE NUMBER

Registration District No. 324 Primary Registration District No. 3072 Registrar's No. 68

1. PLACE OF DEATH a. COUNTY <u>Saline</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Saline</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Marshall</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Marshall</u> <u>09720</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Fitzgibbon hosp.</u>		Length of stay in lb <u>21</u> years	d. STREET ADDRESS (If outside, give location) <u>419 West North St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>James Earl Rader</u>			4. DATE OF DEATH Month Day Year <u>April 17th 1959</u>		
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 12th 1937</u>	9. AGE (In years last birthday) <u>21</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Furniture Store</u>	11. BIRTHPLACE (City and state or country) <u>Marshall, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Jesse Earl Rader</u>	13b. MOTHER'S MAIDEN NAME <u>Mabel Marie Grandstaff</u>	14. NAME OF HUSBAND OR WIFE <u>Elsie Vern Rader</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>493-38-4694</u>	17. INFORMANT Address <u>Mrs Elsie Vern Rader, Marshall, Mo.</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u>			INTERVAL BETWEEN ONSET AND DEATH <u>36 hr</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Subarachnoid Hemorrhage</u>	<u>48 hr</u>	
	DUE TO (c) <u>Right cerebral aneurysm, Right carotid artery</u>	<u>48 hr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>330X</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

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.)
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20c. TIME OF INJURY Hour Month, Day, Year 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
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21. I attended the deceased from Death occurred at <u>4/15/59</u> to <u>4/17/59</u> and last saw him alive on <u>4/17/59</u> <u>II-15 P. M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <u>Harold E. Rother M.D.</u>	22b. ADDRESS <u>Marshall, Mo</u>	22c. DATE SIGNED <u>4/17/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>4-19-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ridge Park cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Marshall Missouri</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Campbell-Lewis Funeral Home</u> <u>Marshall, Missouri</u>	25. DATE RECD. BY LOCAL REG. <u>4-18-59</u>	26. REGISTRAR'S SIGNATURE <u>Earl G. Read</u>
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Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

APR 24 1959

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 *R.W. Campbell Jr.*

Licensed Embalmer No. *3469*

P. O. Address. *Marshall*

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

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