

FILED SEP 10 1957

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

57 0 27 4 6 5
 State File No.

53

BIRTH NO. _____		REG. DIST. NO. <u>32</u>		PRIMARY REG. DIST. NO. <u>4042</u>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY <u>Bollinger</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Bollinger</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Lutesville</u>		c. LENGTH OF STAY (in this place) <u>7yrs</u>		c. CITY OR TOWN <u>Lutesville</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Home</u>				e. STREET ADDRESS (If rural, give location) <u>2090</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>SAMUAL</u>			b. (Middle) <u>HARVE</u>		c. (Last) <u>CRADER</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>9-3-1957</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>12-13-1875</u>		9. AGE (In years last birthday) <u>81</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <u>Bollinger Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Samual G. Crader</u>			13b. MOTHER'S MAIDEN NAME <u>Sarah Nance</u>		14. NAME OF HUSBAND OR WIFE <u>Hattie Crader</u>		
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>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Hattie Crader, Lutesville, Mo.</u>			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Dissection of aortic aneurysm</u> INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis, Generalized. ? years</u> DUE TO (c) <u>Intractable congestive heart failure 6 mos.</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? <u>451X</u> 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) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>5/21</u> , 19 <u>57</u> , to <u>9/3</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9/3</u> , 19 <u>57</u> , and that death occurred at <u>2:10 P.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Dr. Breece M.D.</u> (Degree or title)				23b. ADDRESS <u>Marble Hill, Mo.</u>		23c. DATE SIGNED <u>9/5/57</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>9-5-57</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Bollinger Co. Mem</u>		24d. LOCATION (City, town, or county) (State) <u>Lutesville, Mo.</u>		
DATE REC'D BY LOCAL REG. <u>9-6-57</u>		REGISTRAR'S SIGNATURE <u>Mrs. Buford Crader</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Glenn Ward, Lutesville, Mo.</u>			

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, Student Embalmer No.
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed..... *R. O. Laine*

Licensed Embalmer No. *4532*

P. O. Address..... *Jackson, m*

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.