WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Walker

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

32022

PLACE OF DEATH

County Pettis

Township _____ or Village _____ or City Sedalia (NO. _____, _____ St.; _____ Ward)

Registration District No. 668 File No. _____

Primary Registration District No. 3032 Registered No. 261

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Mary Margaret Ettmueller

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Widowed

DATE OF BIRTH: March (Month) 11 (Day), 1855 (Year)

AGE: 61 yrs. ___ mos. ___ ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country): Hermann, Mo.

PARENTS

NAME OF FATHER: Fred Vallet

BIRTHPLACE OF FATHER (City or town, State or foreign country): Germany

MAIDEN NAME OF MOTHER: Monika Joeli

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Switzerland

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Emma Ettmueller

(ADDRESS) Warrensburg, Mo.

Filed Sept 25, 1916. F. B. Long REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Sept. (Month) 24 (Day), 1916 (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 24, 1916, to Sept 24, 1916, that I last saw her alive on Sept 24, 1916, and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows:

Perforation of Stomach

117A

102

(Duration) — yrs. — mos. -1 ds.

Contributory (SECONDARY) Gastric Ulcer.

(Duration) Not known yrs. ___ mos. ___ ds.

(Signed) E. R. Walker, M. D.

Sept 25, 1916. (Address) Sedalia, Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL: Jefferson City Mo

DATE OF BURIAL: 9-26, 1916

UNDERTAKER: McLaughlin

ADDRESS: Sedalia, Mo.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County _____

Township _____ *or*

Village _____ *or*

City _____ (NO. _____, _____ St.; _____ Ward)

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME _____

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH _____, 1_____ (Month) (Day) (Year)

AGE _____ yrs. _____ mos. _____ ds. | If LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER (City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER (City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191____, _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____, 191____ (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h_____ alive on _____, 191____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

_____

_____

_____

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory _____ (SECONDARY)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

_____, 191____ (Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL _____, 191____
UNDERTAKER	ADDRESS