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.

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

41707

PLACE OF DEATH

County: Livingston Co.

Township: Mercer

or Village:

or City: (NO. St.: Ward)

Registration District No.: 574

Primary Registration District No.: 5683

File No.:

Registered No.:

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

FULL NAME Lettie Ruth Seitter

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Single

DATE OF BIRTH: July (Month) 23 (Day), 1879 (Year)

AGE: 37 yrs. 5 mos. 9 ds.

If LESS than 1 day, hrs. or min.?

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

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

PARENTS

NAME OF FATHER: Michael Seitter

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

MAIDEN NAME OF MOTHER: Amanda Hasick

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Jersey Ill.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): Mo Seitter

(ADDRESS):

Filed Dec 28, 1916. Geo Moore REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Dec (Month) 26 (Day), 1916 (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 1, 1916, to Dec 24, 1916, that I last saw her alive on Dec 24, 1916, and that death occurred, on the date stated above, at 4 p.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of lungs

23A

(Duration) About 7 years yrs. mos. ds.

Contributory (SECONDARY) None

(Duration) yrs. mos. ds.

(Signed) Geo Moore M. D.

Dec 26, 1916 (Address) Dudleyville 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: Plymouth Cem

DATE OF BURIAL: 12-28 1916

UNDERTAKER: C Busby

ADDRESS: Trenton

PLACE OF DEATH

County _____

Township _____ Registration District No. _____
or
Village _____ Primary Registration District No. _____
or
City _____ (NO. _____, _____

FULL NAME _____

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

TATE BOARD OF HEALTH
OF VITAL STATISTICS
IFICATE OF DEATH

File No. _____

egistered No. _____

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

_____

ICATE OF DEATH

_____, 191____
onth) (Day) (Year)

I HEREBY that I attended deceased from

_____, 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