

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

Do not use this space.

32840

1. PLACE OF DEATH

County Buch Registration District No. 86 File No. _____
 Township Wash Primary Registration District No. 5-12 Registered No. 66
 City Industrial City, Mo. (State) Mo. Ward _____

2. FULL NAME

Betty Jean Stetter
 (a) Residence No. 1522 Mitchell Ave (State) _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Nov. 27, 1927</u>		
7. AGE	YEARS	MONTHS
	<u>0</u>	<u>0</u>
		DAYS
		<u>0</u>
		If LESS than 1 day, 2 hrs. or 35 min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)
Industrial City Missouri

10. NAME OF FATHER Gus Stetter

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)
St. Joseph Missouri

12. MAIDEN NAME OF MOTHER Dwaine Mull

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)
North County Missouri

14. INFORMANT (Address)
Gus Stetter 1522 Mitchell Ave

15. FILED 4-27-27 1927 Wausch REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 27, 1927

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw her alive on _____, 19____, and that death occurred, on the date stated above, at _____, 11:50 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
umbilical cord strangulation
1600
1610
 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH, _____

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____

20. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? _____ (Signed) W.H. Morris M. D.
 (Address) 1503 S. Park Ave. St. Joseph, Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Ashland Cemetery DATE OF BURIAL Nov 28 1927

20. UNDERTAKER E.R. Sidenfaden ADDRESS 622 So. 10th

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.

