

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

Do not use this space.

20194
File No. _____
Registered No. 83
St. _____ Ward _____

1. PLACE OF DEATH
County Saline Registration District No. 796
Township _____ Primary Registration District No. 3038
City Marshall, Mo. (No. _____) St. _____ Ward _____

2. FULL NAME Viola Fette
(a) Residence. No. _____ St. _____ 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. da. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND or (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 19 - 1910

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	20	7	0	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Alma, Mo.
(STATE OR COUNTRY) Mo.

10. NAME OF FATHER Wm. J. Fette

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
(STATE OR COUNTRY) unknown

12. MAIDEN NAME OF MOTHER Floora Scharukovst

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Concordia
(STATE OR COUNTRY) Mo.

14. INFORMANT Loise Meyer
(Address) Marshall, Mo.

15. FILED 5-25, 1931 Mr. John H. McQuinn
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-19 1931

17. I HEREBY CERTIFY, That I attended deceased from May 13, 1931, to May 19, 1931, that I last saw her alive on May 8, 1931, and that death occurred, on the date stated above, at 8:50 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pelvic abscess
1398
1224 (duration) yrs. mos. 16 da.
12-30
CONTRIBUTORY Hemorrhage (rupture
(SECONDARY) into caecum) (duration) yrs. mos. 2 da.

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

1 DID AN OPERATION PRECEDE DEATH? Yes DATE OF May 19, 1931

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS Clinical diagnosis
(Signed) W. H. Miller, M. D.

(Address) Marshall, 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 Alma Luth Cem. DATE OF BURIAL May 22 1931

20. UNDERTAKER Alfred H. Bremer ADDRESS Alma, Mo.

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. JUN 29 1931

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Saline
Township
City Marshall (No. St. Ward)

Registration District No. 796
Primary Registration District No. 3038

File No.
Registered No. 82

2. FULL NAME

(a) Residence, No. St. 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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) S

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

19. UNDERTAKER (ADDRESS)

20. FILED 5-25 1931 Mrs. John H. McQuinn Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-19 1931

22. I HEREBY CERTIFY, That I attended deceased from

to 19.....
I last saw h..... alive on....., 19..... Death is said

to have occurred on the date stated above, at.....m.
The principal cause of death and related causes of importance were as follows:

Septic Abscess
abscess emptied into
caecum causing rupture
could find no history of
trauma, not sure if
Other contributory causes of importance
hemorrhage (rupture)
into caecum
abscess was infected

Name of operation Date of
What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury 19.....

Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) M. D.
(Address)

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

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