

REC'D FEB 28 1939

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

4093

Do not use this space.

1. PLACE OF DEATH

(a) County Stoddard Registration District No. 840
(b) Township Rock Creek Primary Registration District No. 6102 Registered No. 2
(c) City Paris R. 2 (d) Street No. _____ St.
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
Mary Rosetta Sutter

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX <u>Female</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>John Sutter</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>9-28-1873</u>		
7. AGE <u>65</u>	YEARS <u>3</u>	MONTHS <u>15</u>
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Housewife</u>		11. Total time (years) spent in this occupation <u>life</u>
9. Industry or business in which work was done, as saw mill, bank, etc.		
10. Date deceased last worked at this occupation (month and year)		
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Paris, Mo</u>		
FATHER	13. NAME <u>John Williams</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Ill.</u>	
MOTHER	15. MAIDEN NAME <u>Elizah Burkes</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Tenn</u>	
17. INFORMANT (ADDRESS) <u>John Sutter</u> <u>Paris, Mo</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Rock Hill</u> DATE <u>1-15-39</u>		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>Wetkin Funeral Home</u> <u>Wester, Mo</u>		
20. FILED <u>Jan 16 1939</u> <u>Dorman Dycus</u> Local Registrar.		

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 12 1939

22. I HEREBY CERTIFY That I attended deceased from Jan 12 1939 to Jan 13 1939
I last saw him alive on Jan 12 1939. Death is said to have occurred on the date stated above, at 2:45 AM.

The principal cause of death and related causes of importance were as follows:

Constriction of lungs
resulting from
chronic
asthmatic
lung

Other contributory causes of importance:

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? no

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)

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify _____
(Signed) E. H. Dycus, M. D.
Address Paris, Mo

112

STATE OF MISSOURI
DEPARTMENT OF HEALTH
BUREAU OF HEALTH OFFICERS

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,

William C. Shelton

or by

Registered Apprentice No. _____, working under my personal supervision.

Signed

William C. Shelton

Licensed Embalmer No. *3929*

P. O. Address *Box 472, Dexter, Mo*

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 this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
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4093-
Do not use this space.

1. PLACE OF DEATH
 (a) County Stoddard Registration District No. 840
 (b) Township Primary Registration District No. 6102 Registered No.
 (c) City (d) Street No. St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Mary Rosetta Dutter
 (a) Residence, No. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) M

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.
65 3 15

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as 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..

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED, 19..

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 13, 1919

22. I HEREBY CERTIFY That I attended deceased from

I last saw him 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:
Congestion of lungs following thro' hard labor - Bronchial pneumonia - Bronchitis - Asthmatic lungs -

Other contributory causes of importance:
Chronic emphysema

Date of onset

Name of operation Date of

What test confirmed diagnosis? 10/12 Was there an autopsy? no

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 E. J. Umare, M. D.
 (Signed) Purico mo-
 (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 COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENT

Local Registrar.

MINNESOTA DEPARTMENT OF REVENUE
COMMISSIONERS OFFICE
ST. PAUL, MINNESOTA

STATE OF MINNESOTA

REVENUE

THE STATE OF MINNESOTA, COUNTY OF [illegible], do hereby certify that [illegible] is the [illegible] of [illegible] and that [illegible] is the [illegible] of [illegible].

IN WITNESS WHEREOF, I have hereunto set my hand and the seal of the State of Minnesota, this [illegible] day of [illegible], 19[illegible].

COMMISSIONER OF REVENUE

STATE OF MINNESOTA
REVENUE

107-156-001