

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

26455
 Do not use this space.

1. PLACE OF DEATH *2*

(a) County *Scott* Registration District No. *814*
 (b) Township *Morland* Primary Registration District No. *6063*
 (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. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME *360 John Vetter*

(a) Residence, No. *Benton Mo* 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 *male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *married*

5A. IF MARRIED, WIDOWED OR DIVORCED HUSBAND OF (OR) WIFE OF *Rose M Vetter*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Feb 22 - 1860*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
80 4 80

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *Retired farmer*

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

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *June 22 1940*

22. I HEREBY CERTIFY That I attended deceased from *June 1*, 19*39* to *June 8*, 19*40*
 I last saw him alive on *June 8*, 19*40* Death is said to have occurred on the date stated above, at *7:30 p.m.*
 The principal cause of death and related causes of importance were as follows:

Carcinoma lips & throat

Date of onset

Other contributory causes of importance:

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Scott Co Mo*

FATHER 13. NAME *Charles Vetter*

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

MOTHER 15. MAIDEN NAME *Unknown*

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

17. INFORMANT (ADDRESS) *Otto Vetter*
Commerce Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE *Benton Mo* DATE *June 25 1940*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *J. S. Hussner Co*
Oven Mo

20. FILED *623*, 19*40* *U. P. Haw*
 Local Registrar.

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) *U. P. Haw* M. D.
 (Address) *Benton 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.

THIS IS A PERMANENT RECORD

45

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, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 26453

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 914

Primary Registration District No. 6063

Registrar's No.

1. PLACE OF DEATH:

(a) County Scott

(b) City or town Moreland
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution..... (Specify whether years, months or days)

In this community.....

3. (a) PRINT FULL NAME John Jetter

3. (b) If veteran name war..... 3. (c) Social Security No.....

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... year

7. Birth date of deceased Feb 22 1860
(Month) (Day) (Year)

8. AGE: Years 80 Months 80 Days 4 If less than one day..... min.

9. Birthplace..... (City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace..... (City, town, or county) (State or foreign country)

14. Maiden name.....

15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) June 23, 1940 (Date received local registrar) (b) Lymand Jetter (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....

(c) City or town..... (If outside city or town limits write "RURAL")

(d) Street No..... (If rural, give location)

(e) If foreign born, how long in U. S. A.?..... years.

20. DATE OF DEATH Month June day 22 year 1940 hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19..... to....., 19.....; that I last saw him alive on....., 19..... and that death occurred on the date and hour stated above.

Immediate cause of death.....

Due to.....

Due to.....

Other conditions..... (Include pregnancy within 3 months of death)

Major findings:
Of operations.....

autopsy.....

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....

(b) Date of occurrence.....

(c) Where did injury occur?..... (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?..... (Specify type of place) While at work?..... (e) Means of injury.....

23. Signature..... (M. D. or other)..... Address..... Date signed.....

SUPPLEMENTARY

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 2641-5

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 814

Primary Registration District No. 6063

Registrar's No. _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH
(a) County Scott
(b) City or town Moreland
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days) (Specify whether

3. (a) PRINT FULL NAME John Vetter
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced w
6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years
7. Birth date of deceased Feb 22 1860
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
90 _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

20. DATE OF DEATH Month June day 22
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of lip and throat

Due to # N. M. D. - Physician
Due to deceased #

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.