

FILED OCT 29 1943

Registration District No. **333**

Primary Registration District No. **3074**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Scott

(b) City or town Beckett

(c) Name of hospital or institution Beckett General O
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution 3 hours
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Stoddard 103

(c) City or town Canslaw Mo. Rural
(If outside city or town limits, write "RURAL")

(d) Street No. Box 203
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Edward Ray Fatters

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 single

6. (b) Name of husband or wife no

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased 7 30 1943
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
	<u>2</u>	<u>15</u>	hr. _____ min.

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

10. Usual occupation Druggist

MOTHER FATHER

11. Industry or business _____

12. Name Raymond Fatters

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

14. Maiden name Jucille Parson

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

16. (a) Informant Raymond Fatters

(b) Address Canslaw Mo

17. (a) Burial (b) Date thereof 10 16 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation mother's

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

(b) Address Canslaw

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 15
year 1943 hour 11 minute 15 P.M.

21. I hereby certify that I attended the deceased from 10-10
1943, to 10-15, 1943
that I last saw him alive on 10-15, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Fatal Pneumonia *Dyspnea*

Due to _____

Due to _____

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

Major findings: 106

Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 [Signature] (M. D. or other) Mo

Address Stoddard Mo Date signed 10-16-43

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

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 do the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

MISSOURI DEPARTMENT OF HEALTH
DIVISION OF PUBLIC HEALTH
400 WEST WASHINGTON ST. ST. LOUIS, MO. 63101

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Nov
Registrar's No.

Registration District No. 333 Primary Registration District No. 3074

WRITE PLAINLY—USE INK—RECORD PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Scott

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

(c) Name of hospital or institution: Sikeston General
(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 _____
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Edward Ray Fetters

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 S

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years _____ months _____ days

7. Birth date of deceased July 20 1943
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____
(Unless than one day, in min.)

9. Birthplace Mo.
(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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 11/7/43 (b) Louise Largent
(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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October Day 15 Year 1943 Hour _____ Minute _____ M.

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

Immediate cause of death Labor Pneumonia

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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

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

35917