

1. PLACE OF DEATH

(a) County Lafayette
(b) City or town Wellington
(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 30 yrs.
years, months or days

3. (a) PRINT FULL NAME George H. TRETTER

3. (b) If veteran, name war None 8. (c) Social Security No. None

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Alvena Tretter 6. (c) Age of husband or wife if alive 62 years
7. Birth date of deceased Sept. 5 1873
(Month) (Day) (Year)

8. AGE: Years 72 Months 6 Days 6 If less than one day _____ hr. _____ min.

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

10. Usual occupation Farming

11. Industry or business _____

MOTHER FATHER { 12. Name George Tretter
13. Birthplace Unknown 9
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Alvena Tretter
(b) Address Wellington, Mo.

17. (a) Wellington Mo. (b) Date thereof 3 13 1945
(Burial, cremation, or other) (Month) (Day) (Year)
(c) Place: burial or cremation Evangelical Cemetery

18. (a) Signature of funeral director Earl James Hume
(b) Address Wellington Mo

19. (a) April - 5 - 1945 (b) Wm W. Baker
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lafayette
(c) City or town Wellington 54
(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.? 1 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 13
year 1945 hour 3 minute 10 A.M.

21. I hereby certify that I attended the deceased from Mar. 5, 1945, to Mar 11, 1945
that I last saw him alive on Mar. 10, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of stomach, liver & bowels

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

PHYSICIAN
Major findings: Of operations 2/6/45
Of autopsy _____
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 R. B. Watts (M. D. or other)
Address Wellington Mo. Date signed 4-12-45

400

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

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

5/8/45

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

W. R. Owen

Licensed Embalmer No.

4205

P. O. Address

Wellington, MA

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.