FILED APR 21 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 12408

Registration District No. 908 — Primary Registration District No. 4549 — Registrar's No. 14

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

1. PLACE OF DEATH:
(a) County: Wright
(b) City or town: Mtn Grove Mo. (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Ryan Hospital (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 .....

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Wright
(c) City or town: Mtn Grove Mo. (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.

3. (a) PRINT FULL NAME: Betty Maurie Fetrow
3. (b) If veteran, name war: 1
3. (c) Social Security No. .....
4. Sex: Female
5. Color or race: White
6. (a) Single, widowed, married, divorced: 0
6. (b) Name of husband or wife: .....
6. (c) Age of husband or wife if alive: 1 years
7. Birth date of deceased: Feb. (Month) 18 (Day) 1941 (Year)
8. AGE: Years: 0 Months: 0 Days: 0 If less than one day: 6 hr. ..... min.
9. Birthplace: Mtn Grove Mo. 0 (City, town, or county) (State or foreign country)
10. Usual occupation: 1
11. Industry or business: 1
MOTHER FATHER
12. Name: Carl Fetrow
13. Birthplace: Iowa (City, town, or county) 1 (State or foreign country)
14. Maiden name: Zelma Soules
15. Birthplace: Cal. (City, town, or county) 1 (State or foreign country)
16. (a) Informant: Carl Fetrow
(b) Address: Mtn Grove Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Feb. 1941 (Month) (Day) (Year)
(c) Place: burial or cremation: Flower
18. (a) Signature of funeral director: Russell Barber
(b) Address: Mtn Grove Mo.
19. (a) 3-1-41 (Date received local registrar) (b) Bernice Montgomery (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Feb. day: 17 year: 1941 hour: 4 a. minute: ..... M.
21. I hereby certify that I attended the deceased from ....., 19..., to ....., 19...; that I last saw her alive on 2/14 ..., 1941; and that death occurred on the date and hour stated above.

Immediate cause of death: Premature 7 months

Due to: .....

Due to: .....

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

Major findings: Of operations: ..... Of autopsy: .....

Duration

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: R Ryan (M. D. or other) .....
Address: Mtn Grove Date signed: 2/19-41

(Licensed Embalmer's Statement on Reverse Side) 1-6-7

RECEIVED
District Health Officer No. 6,
District File Number [redacted] 441-649
Date Filed APR 16 1941

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.

Was not Embalmed

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

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

No. 2B
4-25-41
PI X27852

ROWENA MOORE

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 12408

Registration District No. 908 Primary Registration District No. 45-49 Registrar's No.

1. PLACE OF DEATH

(a) County Wright

(b) City or town (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

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

3. (a) PRINT FULL NAME Betty Marie Fetrow

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced

6. (b) Name of husband or wife

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

7. Birth date of deceased Feb (Month) 18 (Day) 1941 (Year)

8. AGE: Years 5 Months 18 Days Stillborn If less than one day hrs. 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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 5-31-41 (Date received local registrar) (b) Bernice McDonnell (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 17 year 1941 hour minute M.

21. I hereby certify that I attended the deceased from 19, to 19; that I last saw her alive on Feb 17 19 41; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
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? (Specify type of place)

While at work? (e) Means of injury

23. Signature R. A. Ryan (M. D. or other)

Address Mtn Grove Mo Date signed

SUPPLEMENTARY