

**FEB JUL 13 1945**

Registration District No. 275

Primary Registration District No. 3053

Registrar's No. ....

**1. PLACE OF DEATH:**

(a) County Phelps  
(b) City or town Rolla  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Nelle McFarland Memorial Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 7 days (Specify whether  
In this community 7 days  
years, months or days)

**3. (a) PRINT FULL NAME**

Leaner Isabel Fetherhoff

3. (b) If veteran, name war. ....

3. (c) Social Security No. ....

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced W  
6. (b) Name of husband or wife Albert R. 6. (c) Age of husband or wife if alive 9 years  
7. Birth date of deceased Feb. 2, 1871  
(Month) (Day) (Year)

8. AGE: Years 74 Months 4 Days 24 If less than one day hr. min.

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

10. Usual occupation Housewife

**11. Industry or business**

MOTHER FATHER { 12. Name John H. Sweetnam  
13. Birthplace Howard Co Mo  
(City, town, or county) (State or foreign country)  
14. Maiden name Margaret Herndon  
15. Birthplace Howard Co Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant Miss Jeanne Fetherhoff  
(b) Address 4531 McPherson, St Louis, Mo

17. (a) Burial (b) Date thereof June 29, 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Jacksonville, Mo.

18. (a) Signature of funeral director W. B. Johnson  
(b) Address Newburg Mo

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

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Pulaski 85  
(c) City or town 77 Leonard Wood Mo  
(If outside city or town limits, write "RURAL")  
(d) Street No. 6 F Pulaski (If rural, give location)  
(e) Citizen of foreign country? 1 (Yes or No)  
If yes, name country. ....

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month June day 26, year 1945 hour 10 minute 10.9 A.M.

21. I hereby certify that I attended the deceased from June 19, 1945, to June 26, 1945 that I last saw her alive on June 26, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Shock

Due to Surgery - for removal of uterus

Due to .....

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations .....

Of autopsy .....

**ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**

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) .....

Means of injury 0

23. Signature W. B. Johnson (M. D. or other) 0  
Address Rolla, Mo Date signed 6-26-45

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.....

*Lee Johnson*

Licensed Embalmer No. 3392

P. O. Address Newburg 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, fact should be so stated above.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. *July*Registration District No. *275*Primary Registration District No. *3053*

Registrar's No. \_\_\_\_\_

## 1. PLACE OF DEATH:

(a) County *P. Phelps*  
 (b) City or town *Pella*  
 (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 days3. (a) PRINT FULL NAME *Leamer L. Fetterhoff*

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 *wid*

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased *Feb*

(Month)

(Day)

(Year)

8. AGE:

Years *74*Months *4*Days *4*

If less than one day

hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace \_\_\_\_\_

(City, town, or county)

(State or foreign country) *Mo*

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) \_\_\_\_\_

(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) \_\_\_\_\_

(Data received local registrar)

(b) \_\_\_\_\_

(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 \_\_\_\_\_ Day \_\_\_\_\_  
Year *1945* Hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 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 \_\_\_\_\_

Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to *Prolapsed uterus*  
*(Not due to cancer)*Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)Major findings:  
Of operations \_\_\_\_\_Of autopsy *391*

ADDITIONAL

SUPPLEMENTARY

INFORMATION

REQUESTED

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)

(c) Means of injury \_\_\_\_\_

23. Signature *William M. Fetterhoff* (M. D. or other) \_\_\_\_\_Address *Pella, Mo*Date signed *7-16-45*

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

SUPPLEMENTARY

21024