

FILED JAN 10 1944

Registration District No. **704**

Primary Registration District No. **2032**

Registrar's No. **138**

1. PLACE OF DEATH:

(a) County **Johnson**
(b) City or town **Warrensburg.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Warrensburg Clinic.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **6 days.**
(Specify whether years, months or days) **12 yrs.**

3. (a) PRINT FULL NAME **Carrie Louise Sartin.**

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

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **married**

6. (b) Name of husband or wife **J. E. Sartin** 6. (c) Age of husband or wife if alive **68** years

7. Birth date of deceased **Sept. 21 1875**
(Month) (Day) (Year)

8. AGE: Years **68** Months **3** Days **0** If less than one day hr. min.

9. Birthplace **Cole Camp Mo**
(City, town, or county) (State or foreign country)

10. Usual occupation **House keeper**

11. Industry or business

MOTHER FATHER { 12. Name **Henry C. Fowler.**
13. Birthplace **Cole Camp Mo.**
(City, town, or county) (State or foreign country)
14. Maiden name **Susan Conrad.**
15. Birthplace **unknown Germany**
(City, town, or county) (State or foreign country)

16. (a) Informant **Je E. Sartin.**

(b) Address **Warrensburg. Mo.**

17. (a) **Burial** (b) Date thereof **12-22-43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Warsaw. MO.**

18. (a) Signature of funeral director **Arthur W. Phillips**

(b) Address **Warrensburg. MO.**

19. (a) **Dec 21, 1943** (b) **Lesla M. Williams**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **Johnson**
(c) City or town **Warrensburg.**
(If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec**, day **21**, year **1943** hour **3** minute **30 P.M.**

21. I hereby certify that I attended the deceased from **Oct. 27 1943** to **Dec 21 1943**
that I last saw him alive on **Dec 21 1943**
and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic myocarditis** Duration **2 yrs**

Due to **Myocardial Cardio-Vascular Disease** **4 yrs**

Due to **Bronchial Asthma** **15 yrs**
Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **930** 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 **Ch. Johnson M.D.** (M. D. or other)
Address **Warrensburg, Mo.** Date signed **22/21/43**

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

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

1-2-44

DEC 19 1957

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 *R.A. Phillips*

Licensed Embalmer No. *2320*

P. O. Address *Warrensburg, 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.