

FILED NOV 3 1945 STANDARD CERTIFICATE OF DEATH

State File No. 33703

Registration District No. 114

Primary Registration District No. 4186

Registrar's No. 35

1. PLACE OF DEATH: 23010  
(a) County Franklin  
(b) City or town Sullivan  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: At Home  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution All her life  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Carrie Elizabeth Warfield

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

4. Sex Female  
5. Color or race W  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Robert Warfield  
6. (c) Age of husband or wife if alive 67 years  
7. Birth date of deceased Dec. 14 1887  
(Month) (Day) (Year)

8. AGE: Years 57 Months 9 Days 23  
If less than one day hr. min.

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

10. Usual occupation At Home

11. Industry or business

MOTHER FATHER { 12. Name Page Harmon  
13. Birthplace Crawford Co. Mo. (City, town, or county) (State or foreign country)  
14. Maiden name Nancy Pratt  
15. Birthplace Missouri. (City, town, or county) (State or foreign country)

16. (a) Informant Robert Warfield  
(b) Address Sullivan, Mo.  
17. (a) Burial (b) Date thereof 10-11-1945  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Sullivan, Mo.

18. (a) Signature of funeral director J. T. Williams  
(b) Address Sullivan, Mo.

19. (a) 10-9-45 (b) O. A. Prater M.D.  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Franklin  
(c) City or town Sullivan, Mo.  
(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 Oct. day 8th.  
year 1945 hour 7:30 minute 30 p.m.  
21. I hereby certify that I attended the deceased from 10-8 to 10-8 1945  
that I last saw him alive on 10-8 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Coronary thrombosis  
Duration 10 minutes

Due to  
Due to

Other conditions by peritonsillar abscess  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations  
Of autopsy none  
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 O. A. Prater (M. D. or other)  
Address Sullivan Date signed 10/9/45

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

1447

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED  
District Health Officer No. 9,

District File Number \_\_\_\_\_

Date Filed 11-2-45

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 J. T. Williams  
Licensed Embalmer No. 427

P. O. Address Sullivan, 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.**