

FILED JAN 19 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

452

State File No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 47 PRIMARY REG. DIST. NO. 3008 Registrar's No. 73

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Callaway</u>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>Missouri</u> b. COUNTY <u>Callaway</u> |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Fulton</u> |  | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Fulton</u>   |  |
| c. LENGTH OF STAY (In this place) <u>3 years</u>   |  | d. STREET ADDRESS (If rural, give location) <u>Short St.,</u>  |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Callaway County Hospital</u>                    |  |  |  |

|                                     |                           |                        |                           |                                       |
|-------------------------------------|---------------------------|------------------------|---------------------------|---------------------------------------|
| 3. NAME OF DECEASED (Type or Print) | a. (First) <u>Raymond</u> | b. (Middle) <u>Lee</u> | c. (Last) <u>Warfield</u> | 4. DATE OF DEATH (Month) (Day) (Year) |
|                                     |                           |                        |                           | <u>Jan. 11 1949</u>                   |

|                    |                               |  |  |   |   |   |
|--------------------|-------------------------------|--|--|---|---|---|
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Divorced</u> | 8. DATE OF BIRTH <u>March 17, 1914</u> | 9. AGE (In years last birthday) <u>34</u> | IF UNDER 1 YEAR Months <u>10</u> Days <u>25</u> | IF UNDER 2 HRS. Hours <u>1</u> Min. <u>54</u> |
|--------------------|-------------------------------|--|--|---|---|---|

|  |  |   |                              |
|--|--|---|------------------------------|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>In Ore Mine</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>Invalid</u> | 11. BIRTHPLACE (State or foreign country) <u>Tebbetts, Missouri</u> | 12. CITIZEN OF WHAT COUNTRY? |
|--|--|---|------------------------------|

|   |   |                             |
|---|---|-----------------------------|
| 13a. FATHER'S NAME <u>Harrison Warfield</u> | 13b. MOTHER'S MAIDEN NAME <u>Maudie Justice</u> | 14. NAME OF HUSBAND OR WIFE |
|---|---|-----------------------------|

|   |                                     |   |         |
|---|-------------------------------------|---|---------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u> | 16. SOCIAL SECURITY NO. <u>None</u> | 17. INFORMANT'S SIGNATURE OR NAME <u>Harrison Warfield, Fulton, Mo.</u> | ADDRESS |
|---|-------------------------------------|---|---------|

|   |  |  |                                  |
|---|--|--|----------------------------------|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION  |  | INTERVAL BETWEEN ONSET AND DEATH |
|   | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Addison's Disease</u>  |  | <u>3 yrs.</u>                    |
|   | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <u>Partial Paralysis legs.</u> <u>1936</u><br>DUE TO (c) <u>Fract. Spine</u> <u>1936</u> |  |                                  |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. <u>Urinary Sepsis Plur.</u> <u>1936</u>   |  |  |                                  |

|                        |                                  |   |
|------------------------|----------------------------------|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |
|------------------------|----------------------------------|---|

|  |  |   |
|--|--|---|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) |
|  |  | <u>274X</u>                                     |

|  |  |                            |
|--|--|----------------------------|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? |
|--|--|----------------------------|

22. I hereby certify that I attended the deceased from 1947 to Death, 1949, that I last saw the deceased alive on Jan 10, 1949, and that death occurred at 2:04 m., from the causes and on the date stated above.

|  |                                 |                                 |
|--|---------------------------------|---------------------------------|
| 23a. SIGNATURE (Degree or title) <u>John J. Brown M.D.</u> | 23b. ADDRESS <u>Fulton, Mo.</u> | 23c. DATE SIGNED <u>1-12-49</u> |
|--|---------------------------------|---------------------------------|

|   |                               |   |  |
|---|-------------------------------|---|--|
| 24a. BURIAL (City, town, or county) (State) | 24b. DATE <u>Jan 13, 1949</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest</u> | 24d. LOCATION (City, town, or county) (State) <u>Fulton, Mo.</u> |
|---|-------------------------------|---|--|

|  |  |  |                            |
|--|--|--|----------------------------|
| DATE REC'D BY LOCAL REG. <u>Jan 14, 1949</u> | REGISTRAR'S SIGNATURE <u>Joice Morcock</u> | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Wallace Funeral Home</u> | ADDRESS <u>Fulton, Mo.</u> |
|--|--|--|----------------------------|

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

RECEIVED  
District Health Officer No. 9  
District File Number  
Date Filed  
JAN 18 1949

JAN 21 1949

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.....

Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

Signed *Donald C. Browning*

Licensed Embalmer No. *2724*

P. O. Address *Fulton 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.