N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County: Montgomery

Township: Prairie P

or Village: Nat. Spring

or City: Mo (NO. ..... St.: ..... Ward)

Registration District No. 591 — File No. 14032

Primary Registration District No. 5789 — Registered No. 12

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME William A Sparks

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Married

DATE OF BIRTH: May (Month) 5 (Day) 1893 (Year)

AGE: 24 yrs. 8 mos. 24 ds. — If LESS than 1 day, ... hrs. or ..... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): Farm

BIRTHPLACE (City or town, State or foreign country): Paddington Barton Co Mo

PARENTS
NAME OF FATHER: John Sparks
BIRTHPLACE OF FATHER (City or town, State or foreign country): Cowlesca Mo
MAIDEN NAME OF MOTHER: Mary Parrish
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Berry Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Sparks

(ADDRESS) Bocklaus Mo R2

Filed May 10, 1918. C. N. Rigg. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: April (Month) 29 (Day), 1918 (Year)

I HEREBY CERTIFY, that I attended deceased from Nov 15, 1918, to April 29, 1918, that I last saw him alive on April 29, 1918, and that death occurred, on the date stated above, at 7.9 m.

The CAUSE OF DEATH* was as follows:

Viscera Morbus gallicus, 34 hr

(Duration) 2 yrs. 10 mos. 1 ds.

Contributory: ✓

SECONDARY: ✓ (Duration) — yrs. — mos. — ds.

(Signed) C. F. Collins M. D.

4/29, 1918 (Address) Lumsden Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL: Brush Creek cem

DATE OF BURIAL: Apr 30 1918

UNDERTAKER: Chas S. Murphy

ADDRESS: Bucklaus Mo

PLACE OF DEATH

County.....

Township ..... or Village ..... or City ..... (NO. ....., ... St.; ..... Ward)

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. .....

Primary Registration District No. .....

File No. .....

Registered No. .....

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write the word*)

DATE OF BIRTH

..... (Month) ..... (Day), 1..... (Year)

AGE ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(ADDRESS) .....

Filed ....., 191....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

..... (Month) ..... (Day), 191..... (Year)

I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191....., that I last saw h..... alive on ....., 191....., and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

.....

.....

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

....., 191.... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	....., 191....
UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. Age should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.