

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

Do not use this space.

5120

1. PLACE OF DEATH

County..... Stone Registration District No. 847 File No.
 Township..... Williams Primary Registration District No. 6112, 6203 Registered No.
 City..... (No.) St. Ward)

2. FULL NAME..... Charlie Miller Sparger.
 (Norton)

(a) Residence. No. St. Ward.
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male. 4. COLOR OR RACE White. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Nancy Ann Sparger.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1/1

7. AGE 83 YEARS 2 MONTHS 13 DAYS IF LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer.
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Lewistown,
 (STATE OR COUNTRY) Illinois.

10. NAME OF FATHER (Unknown)

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (Unknown)
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER (Unknown)

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (Unknown)
 (STATE OR COUNTRY)

14. INFORMANT W.R. Moore,
 (Address) Baxter, Missouri.

15. FILED 1-25-1929 J. S. Hoffell REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 26, 1929.

17. I HEREBY CERTIFY, That I attended deceased on Jan. 15, 1929, to Jan. 26, 1929.
 that I last saw h. im. alive on January 15, 1929, and that death occurred, on the date stated above, at 4.50 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

"Unknown"

200K 205B
 (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY)
 (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH. No. DATE OF.....
 WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed)..... C. E. Miller M. D.

Jan. 26, 1929 (Address) Blue Eye, Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL McCullough, Cemetry, DATE OF BURIAL 1/27-- 1929

20. UNDERTAKER J. S. Hoffell ADDRESS Baxter

If in plain terms, so that it may be properly classified. Exact statement. AGE should be state.

Handwritten signature or mark

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Stone
Township Williams
City..... (No..... St..... Ward)

Registration District No. 844
Primary Registration District No. 6112

File No.....
Registered No.....

2. FULL NAME

Charlie Melton Sparger

(a) Residence. No..... St..... Ward.....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 13 - 1870

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>58</u>	<u>2</u>	<u>13</u>		

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN).....
(STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

14. INFORMANT (Address).....

15. FILED 124 1929 J. B. Chappell REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 26 1929

17. I HEREBY CERTIFY, That I attended deceased from....., 19..... to....., 19..... that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at.....

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY)..... (duration)..... yrs..... mos..... ds.....
..... (duration)..... yrs..... mos..... ds.....

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. 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.

REGISTRATION FEE SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE. SCRIP 14W

SUPPLEMENTARY

No. 5120