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

Do not use this space.

43297

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

1. PLACE OF DEATH
County Worth
Township Smith
City Allendale (No. ..., St., Ward)
Registration District No. 903
Primary Registration District No. 6211
File No. 2
Registered No.

2. FULL NAME James M. Sparks
(a) Residence. No. Allendale Mo. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U.S., if of foreign birth? ✓ yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS	
3. SEX	Male
4. COLOR OR RACE	White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)	Divorced (Married struck out)
5a. If Married, Widowed, or Divorced HUSBAND OF (or) WIFE OF	Martha Sparks
6. DATE OF BIRTH (month, day and year)	July 17 1852
7. AGE	77 Years, 4 Months, 29 Days; If LESS than 1 day, ...hrs. or ...min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work	Shoe repairer
(b) General nature of industry, business, or establishment in which employed (or employer)	✓
(c) Name of employer	✓ Self
9. BIRTHPLACE (city or town)	Des Moines
(State or country)	Ill. (Mercer Co)
10. NAME OF FATHER	Solomon Sparks
11. BIRTHPLACE OF FATHER (city or town)	Des Moines
(State or country)	England
12. MAIDEN NAME OF MOTHER	Cordell
13. BIRTHPLACE OF MOTHER (city or town)	Des Moines
(State or country)	North Carolina
14. Informant	(Son) M. G. Sparks
(Address)	Maryville Mo.
15. Filed	1/10 1930 John Adams, Registrar

MEDICAL CERTIFICATE OF DEATH	
16. DATE OF DEATH (month, day and year)	Dec 12 1929
17. I HEREBY CERTIFY, That I attended deceased from	Dec 10 1929 to Dec 12 1929
that I last saw h... alive on	Dec 11 1929, and that death occurred, on the date stated above, at 1:30 a.m.
THE CAUSE OF DEATH* was as follows:	Nephritis Acute; 130; 565; 162 (duration) 2 yrs. mos. ds.
CONTRIBUTORY (secondary)	(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?	✓
Did an operation precede death?	No. Date of ✓
Was there an autopsy?	No
What test confirmed diagnosis?	Physical findings
(Signed)	E. J. Rake, M. D.
, 19 (Address)	Grant City 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	DATE OF BURIAL
Allendale Cem	12/13 1929
20. UNDERTAKER	ADDRESS
Family	Allendale

3 9 2 8

CLAIMS should state

MISSOURI STATE BOARD OF HEALTH
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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

SUPPLEMENTARY

1. PLACE OF DEATH.
County Worth — Registration District No. 903 — File No. ......
Township Smith — Primary Registration District No. 6211 — Registered No. 22
City ...... (No. ...... St. ...... Ward)

2. FULL NAME James M. Sparks
(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
M	W	Div.

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

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

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ......min.

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)

PARENTS
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 2/10 John Andrews REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 12 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 ......m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Nephritis
[illegible] with Rheumatism
(duration) ......yrs. ......mos. ......ds.

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

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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
	19
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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

5-43297