

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.

REC'D APR 10 1939

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

11678
Do not use this space.

1. PLACE OF DEATH *New Madrid 2*

(a) County *Stoddard 1* Registration District No. *605*

(b) Township *Como* Primary Registration District No. *4359* Registered No. _____

(c) City _____ (d) Street No. _____ (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____

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

2. PRINT FULL NAME *Al¹⁰⁰⁰ J. Sparkman (Attorney)*

(a) Residence, No. _____ St. (If nonresident, give city or town and State)

(Usual place of abode, if no street address, write county or city)

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 *Minnie Sparkman*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *March 9-1875*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<i>64</i>	<i>0</i>	<i>11</i>	

8. Trade, profession, or particular kind of work done, as *sawyer, bookkeeper, etc.* *Farmer*

9. Industry or business in which work was done, as saw mill, bank, etc. _____

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Mo. 0*

FATHER

13. NAME *John Sparkman* ;

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Tenn. 1*

MOTHER

15. MAIDEN NAME *Denica Crews*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Tenn.*

17. INFORMANT *Minnie Sparkman* (ADDRESS) *Risco*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Leera - Mo.* DATE *3-23-1939*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *Landers Funeral Home Campbell - Mo.*

20. FILED *351* - 1939 *Dr. G. W. Husted* Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *March 20 - 1939*

22. I HEREBY CERTIFY, That I attended deceased from *Mar. 20*, 1939, to *Mar. 20*, 1939

I last saw him alive on *(did not see him)* 19..... Death is said to have occurred on the date stated above, at *6 P.* m.

The principal cause of death and related causes of importance were as follows:

Sudden Death
cause unknown

Date of onset *D.K.*

Other contributory causes of importance: *200 lb*

Name of operation *Hysterectomy* Date of _____

What test confirmed diagnosis *Hysterectomy* Was there an autopsy? *no*

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? *no*

If so, specify _____ (Signed) *Dr. Edward Ford*, M. D.

(Address) *Parma, Mo.*

534

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.....

Licensed Embalmer No.....

P. O. Address.....

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, above space should be left blank.