

350 JUN 24 1939

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

Do not use this space.

1. PLACE OF DEATH

County Madison
Township 1st
City Advance (No. 162)

Registration District No. 934
Primary Registration District No. 4505

File No. 19955
Registered No. 23
St. _____ Ward _____

2. FULL NAME

Odell Corcose Sparkman

(a) Residence No. Advance St. _____ Ward _____
(Usual place of abode) (if nonresident, give city or town and State)

Length of residence in city or town where death occurred 1 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) youth

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 30 1926

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
12 7 19

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) Brownwood
(STATE OR COUNTRY) Mo

10. NAME OF FATHER John Sparkman

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

12. MAIDEN NAME OF MOTHER Laura Wallace

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

14. INFORMANT John Sparkman
(Address) Advance Mo

15. FILED June 5 1939 D S McKeel REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 19 1939

17. I HEREBY CERTIFY, That I attended deceased from May 18 1939, to May 19 1939 that I last saw him alive on May 18 1939 and that death occurred, on the date stated above, at 5 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Jacksonian Epilepsy
first & only time to see the Patient. (duration) _____ yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 87 hr
(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? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) E. C. Masters M. D.

, 19 _____ (Address) Advance, Mo 3

*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 Balch Cemetery, Mo DATE OF BURIAL May 19 1939

20. UNDERTAKER Glenn S. Meryant ADDRESS Advance, Mo

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.

RECORDS—THIS IS A PERMANENT RECORD

