

Registration District No. 67

Primary Registration District No. 5702c

Registrar's No. 3

1. PLACE OF DEATH
(a) County Bollinger
(b) City or town Rural
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days _____

3. (a) PRINT FULL NAME Birtha Arrilla Sparks
8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced _____
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased 2 3 1939
(Month) (Day) (Year)

8. AGE: Years _____ Months 11 Days 9 If less than one day _____ hr. _____ min.

9. Birthplace Marble Hill Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
12. Name Jessie Joe Sparks
13. Birthplace _____
14. Maiden name Effe Almeda Sparks
15. Birthplace _____

16. (a) Informant's own signature _____
(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Lesley Cemetery

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) 3-2-1940 (b) Martha A. Illers
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Bollinger
(c) City or town Marble Hill
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month February day 7
year 1940 hour 6 minute 30 A.M.
21. I hereby certify that I attended the deceased from Feb. 7
_____, 19____, to _____, 19____;
that I last saw h _____ alive on _____ dead _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Peritonitis Duration _____
Due to Strangulated Hernia
Due to _____
Other conditions 10
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature John J. Myers (M. D. or other) MD
Address Lefloreville Mo Date signed Feb 7 1940

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Rev. 5-17-39

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.

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.