MARGIN RESERVED FOR BINDING

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

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.

V. S. No. 2.
50M-9-19-38
I X16605

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

8475
Do not use this space.

1. PLACE OF DEATH

(a) County Vernon — Registration District No. 875

(b) Township Washington — Primary Registration District No. 6162 — Registered No. 50

(c) or City Nevada — (d) Street No. State Hosp #3 St.
(If death occurred in Hospital or Institution, write its name instead of street and number)

(e) Length of residence in city or town where death occurred 19 yrs. 8 mos. 4 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Walter J Sparks

(a) Residence, No. Sarcoxie, Mo. St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 8 1869

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ... min.
	71	0	10	

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Day Laborer
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) Missouri

FATHER
13. NAME Unknown
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

MOTHER
15. MAIDEN NAME Eliza June Duncan
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (ADDRESS) Records, State Hosp #3, Nevada

18. BURIAL, CREMATION, OR REMOVAL
PLACE Hosp. Cemt. DATE 2/20 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Eichinger Funeral Home Nevada Mo

20. FILED 2-20 1940 Allen V Hays Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb. 18 1940

22. I HEREBY CERTIFY, That I attended deceased from Aug 24th, 1939, to Feb 18th, 1940
I last saw him alive on Feb 18th, 1940. Death is said to have occurred on the date stated above, at 3:15 p.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Congestive Heart Failure	

Other contributory causes of importance:

Gen. arterio sclerosis

Name of operation ..... Date of .....
What test confirmed diagnosis? Clinical Was there an autopsy? yes

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?
If so, specify .....
(Signed) G. S. Waraich, M. D.
(Address) State Hospital No 3 Nevada, Mo

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7,
District File Number 3-40-360
Date Filed 3-4-40

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 Mark Eichman

Licensed Embalmer No. C 26 56

P. O. Address Nevada Mo.

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.