

FILED MAY 13 1948

Primary Registration District No. 611718

Registrar's No.

1. PLACE OF DEATH:

(a) County SCOTT
(b) City or town ILLMO PACK
(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 60 YRS.
In this community 60 YRS.
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County SCOTT
(c) City or town ILLMO MO
(d) Street No. 100
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME MARY JANE SPARKS

3. (b) If veteran, name war NO 3. (c) Social Security No. NO

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced WIDOWED

6. (b) Name of husband or wife 6. (c) Age of husband or wife if alive years

7. Birth date of deceased OCT 1 1957

8. AGE: Years 87 Months 7 Days 26 If less than one day hr. min.

9. Birthplace ATLANTA GA

10. Usual occupation HOUSE WIFE

11. Industry or business

MOTHER FATHER { 12. Name WILLIAM MATHIS
13. Birthplace ATLANTA, GA
14. Maiden name SARAH NDIE
15. Birthplace ATLANTA, GA

16. (a) Informant PERRY LONG (b) Address ILLMO MO

17. (a) BURIAL (b) Date thereof 4 27/48
(c) Place: burial or cremation BRIAR CEMETARY

18. (a) Signature of funeral director DISPLINE HOFF & HUBBARD
(b) Address ILLMO MO

19. (a) X-29-48 (b) S. J. ...
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 27 year 1948 hour 7 P.M. minute M.

21. I hereby certify that I attended the deceased from Feb 28 1944 to April 28 1944 that I last saw her alive on April 28 1944 and that death occurred on the date and hour stated above.

Immediate cause of death: Respiratory Failure
Due to: Lobes Pneumonia
Due to: General weakness and infirmities of old age.
Other conditions: Chronic Myocarditis

Major findings: Of operations 108 Of autopsy

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?
(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 Denton J. Wilson M. D. or other DO. Address Springfield, Mo. Date signed 4/28/48

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

RECEIVED

District Health Office No. 2,

District File Number 544-720

Date Filed 5-11-44

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, fact should be so stated above.