

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED OCT 11, 1944

Registration District No. _____

Primary Registration District No. 3000

Registrar's No. 240

1. PLACE OF DEATH:

(a) County ADAIR
(b) City or town KIRKSVILLE
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: GRIM SMITH HOSPITAL
(If not in hospital or institution, write street number or local name)
(d) Length of stay: In hospital or institution Health 18 hrs
(Specify whether years, months or days) lifetime

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County PUTNAM
(c) City or town Washington - Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Washington
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME HUGH DANIEL SPARKS

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

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced SINGLE

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

7. Birth date of deceased AUGUST 17 1925
(Month) (Day) (Year)

8. AGE: Years 19 Months 0 Days 19 If less than one day _____ hr. _____ min.

9. Birthplace PUTNAM Co. MISSOURI
(City, town, or county) (State or foreign country)

10. Usual occupation AT HOME

11. Industry or business AT HOME

12. Name Rollie F Sparks

13. Birthplace PUTNAM Co. MO
(City, town, or county) (State or foreign country)

14. Maiden name Rolla Marie Martin

15. Birthplace PUTNAM Co. MO
(City, town, or county) (State or foreign country)

16. (a) Informant Rollie F Sparks
(b) Address Washington, Mo

17. (a) Burial (b) Date thereof Sept 8-1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation ROSE CEMETERY

18. (a) Signature of funeral director Wm Stock Funeral Home
(b) Address Unionville Mo. By Special Committee

19. (a) 9-9-44 (b) Maude J. Wagner
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION:

20. DATE OF DEATH: Month September day 6th
year 1944 hour 7 minute 20 A.M.

21. I hereby certify that I attended the deceased from January, 1941, to Sept 6, 1944;
that I last saw him alive on Sept 6, 1944;
and that death occurred on the date and hour stated above.

Immediate cause of death - Myocardial failure
gradual

Due to (came into hospital in myocardial condition & lived about 12 hrs)
Due to (Glucose insulin + etc. of no avail)

Other conditions Severe diabetes
(Include pregnancy within 3 months of death) 3 yrs

Major findings: Of operations - None
Of autopsy None

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 George E. Grim (M. D. or other) MD
Address Marionville, Mo Date signed 9-6-44

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

MOTHER FATHER

Duration 48 hrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

JUN 30 1947

MAY 17 1957

RECEIVED

District Health Officer No. 10

District File Number 10-44-1707

Date Filed OCT 10 1944

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

working under my personal supervision.

Signed

John N. Comstock

Licensed Embalmer No.

3891

P.O. Address

Unionville, 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, fact should be so stated above.