

FILED JUN 9 1945

Registration District No. 33

Primary Registration District No. 3010

Registrar's No. 134

1. PLACE OF DEATH:

(a) County Cape Girardeau

(b) City or town Daisy
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Southwest Missouri Hosp.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 19 hrs.
(Specify whether years, months or days)

In this community 19 hrs.

2. US RESIDENCE OF DECEASED:

(a) State Mo. (b) County Cape Gir.

(c) City or town Daisy
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Baby Girl Sparks

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Female 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 5-5-45
(Month) (Day) (Year)

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

9. Birthplace Cape Girardeau Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation _____

MOTHER FATHER

11. Industry or business _____

12. Name S. V. Sparks

13. Birthplace Salem Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Anna Roberts

15. Birthplace Daisy Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant S. V. Sparks

(b) Address Daisy Mo.

17. (a) Burial (b) Date thereof 5-6-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Salem Cem.

18. (a) Signature of funeral director Wilson & Stiles - St. Louis

(b) Address Larkson Mo.

19. (a) 5-10-45 (b) F. M. Phelps
(Date after local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 6
year 45 hour 25 minute p.m.

21. I hereby certify that I attended the deceased from 5-4, 1945, to 5-6, 1945
that I last saw her alive on 5-4, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death _____
prematurity
Ataxidasis

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Duration _____

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

Major findings:
Of operations ✓

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? _____
(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) (c) Means of injury _____

23. Signature Arthur M. Estes (M. D. or other) Phys.
Address Daisy Mo. Date signed 5-8-45

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

16
1
4

RECEIVED

District Health Officer No. 4
District File Number 645-681
Date Filed 6-6-45

W. Wilson

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.