

No. 2
1-5-43
5-17-39
I X36871

FILED JUN 10 1948

Registration District No. 328

Primary Registration District No. 6225

Registrar's No. 63

1. PLACE OF DEATH:

(a) County Winn

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

(c) Name of hospital or institution: State Hospital #32
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 yrs 8 days
(Specify whether years, months or days)

In this community 2 yrs 8 days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson

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

(d) Street No. 2608 Kennett
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME WILLIAM SPARKS

3. (b) If veteran, name war No

3. (c) Social Security No. ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 24 year 1946 hour 18 minute 15 P.M.

21. I hereby certify that I attended the deceased from 12-1-1944 to 5-24-46, 1946 and that I last saw him alive on 5-24-46 1946 and that death occurred on the date and hour stated above.

Immediate cause of death: Pulmonary Tuberculosis Duration _____

4. Sex male 5. Color or race White

6. (a) Single, widowed, married, divorced wid

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

7. Birth date of deceased June 25 1875
(Month) (Day) (Year)

Due to _____

Due to _____

Other conditions: Meningo-encephalitis
(Include pregnancy within 3 months of death)

8. AGE: Years 70 Months 10 Days 29 If less than one day _____ hr. _____ min.

9. Birthplace: Indiana
(City, town, or county) (State or foreign country)

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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10. Usual occupation: Laborer

11. Industry or business: (Joe Sparks)

MOTHER FATHER

12. Name: Joe Sparks

13. Birthplace: Indiana
(City, town, or county) (State or foreign country)

14. Maiden name: Fannie Turner

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

16. (a) Informant: Hospital record

(b) Address: Nevada, Mo

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 5-25-46
(Month) (Day) (Year)

(c) Place: burial or cremation: W. Washington, Mo

18. (a) Signature of funeral director: Mrs. B. L. Fowler

(b) Address: Kennett, Mo

19. (a) 5-24-46 (Date received local registrar) (b) Wathyn Vance (Registrar's signature)

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: R. H. Wall (M. D. or other) _____

Address: Nevada Mo Date signed: 5/24/46

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

RECEIVED

District Health Officer No. 7,

District File Number 5-46-564

Date Filed 6-6-46

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 E. H. Wise

Licensed Embalmer No. 2570

P. O. Address Kansas City, 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.