

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

THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **843**
 Registrar's No. **98**

FILED FEB 14 1947
 Registration District No. **2000**

Primary Registration District No. **2000**

1. PLACE OF DEATH:
 (a) County Greene
 (b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
781 College St., 1
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Albert Sparks
 3. (b) If veteran, name war None
 3. (c) Social Security No. None

4. Sex Male 5. Color or race White
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Nona Sparks
 6. (c) Age of husband or wife if alive 62 years
 7. Birth date of deceased June 21 1877
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
69	7	11	hr. min.

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

10. Usual occupation Retired Physcian

11. Industry or business Physcian

MOTHER, FATHER

{	12. Name	<u>Vinah Sparks</u>	+
	13. Birthplace	<u>London England</u>	
	14. Maiden name	<u>Mary Combs.</u>	
	15. Birthplace	<u>London England</u>	

16. (a) Informant Mrs. Nona Sparks

(b) Address 781 College Springfield Mo.

17. (a) Burial (b) Date thereof 2/5/47
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Maple Park Cem

18. (a) Signature of funeral director J. W. Klingner Co.
 (b) Address Springfield Mo.

19. (a) 2-3-47 (b) W. E. Handy M.D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo. (b) County Greene **39**
 (c) City or town Springfield
(If outside city or town limits, write "RURAL")
 (d) Street No. 781 College
(If rural, give location)
 (e) Citizen of foreign country? No. (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Feb. day 2
 year 1947 hour 8 minute 00 P.M.
 21. I hereby certify that I attended the deceased from 28 Jan
1947 to 2 Feb, 1947,
 that I last saw him alive on 2 Feb, 1947,
 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Artery disease **2 yrs +**
 Due to Generalized Arterio sclerosis **undet.**

Due to _____
 Other conditions 94A
(Include pregnancy within 3 months of death)

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)
 (e) Means of injury 0

23. Signature Stanley A. Peterson M.D. (Physician)
 Address 500 Holland Bldg. Springfield signed 3 Feb 47

DEPARTMENT OF COMMERCE
BUREAU OF LABOR
S. No. 2
17-45
17-30

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 May Rhodes

Licensed Embalmer No. 4071

P. O. Address Springfield

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.