MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

FILED APR 18 1947

14755
Do not use this space.

1. PLACE OF DEATH
(a) County St. Francis — Registration District No. 316
(b) Township — Primary Registration District No. 3059 — Registered No. 122 110
(c) City Bonne Terre, Mo. (d) Street No. ..... St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Charlie Sprinkle
(a) Residence, No. Washington Co. Mo. St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Annie L. Sprinkle
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 10 1886
7. AGE: Years 60 | Months 3 | Days 25 | If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) March 47
11. Total time (years) spent in this occupation Life

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Franklin Co. Mo.

FATHER
13. NAME Winslow Sprinkle
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) South Carolina, U.S.A.

MOTHER
15. MAIDEN NAME Minerva Simmons
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Sullivan Mo.

17. INFORMANT Pauline Sprinkle
(ADDRESS) Potosi Mo.
18. BURIAL, CREMATION, OR REMOVAL Burial
PLACE Potosi Mo. DATE 4-7-47, 19
19. FUNERAL DIRECTOR (NAME) Mrs. Luther Sparks
(ADDRESS) Potosi Mo.
20. FILED 4-16, 1947 Esther Rudolph, Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 5, 1947, 19

22. I HEREBY CERTIFY, That I attended deceased from March 26, 1947, to April 5, 1947. I last saw him alive on April 5, 1947. Death is said to have occurred on the date stated above, at 6:30 P.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Carcinomatosis (primary site undetermined)	?
Other contributory causes of importance: Subhepatic abscess 2. Arteriosclerotic heart disease 3. Femoral vein thrombus, bilateral.	1 Mo. a 5 days

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify
(Signed) Van W. Taylor, M. D.
(Address) Bonne Terre, Mo.

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

SOM-1-12 I X14028

JUL 25 1947
JUN 2 1947

RECEIVED
District Health Officer No. 4
District File Number 447-555
Date Filed 4-21-47

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 Murphy L. Sparks

Licensed Embalmer No. 4236

P. O. Address Flat River, 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, above space should be left blank.