S. No. 2
M—1/47
v. 5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED SEP 23 1947 #76231

Registration District No. 318

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 33044

Registrar's No. 8662

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

1. PLACE OF DEATH:

(a) County

(b) City or town St.Louis,Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St.Louis City Hospital-Max C. Starkloff
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 000

(c) City or town ST. LOUIS 17
(If outside city or town limits, write "RURAL")

(d) Street No. 4479 FOREST PARK BLV.
Memorial 19 (If rural, give location)

(e) Citizen of foreign country? (Yes or No) 7

If yes, name country

3. (a) PRINT FULL NAME JOHN SPARKS

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M. O

5. Color or race W.

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

6. (b) Name of husband or wife CARRIE SPARKS.

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

7. Birth date of deceased SEPT. (Month) 7 (Day) 1870 (Year)

8. AGE: Years 77 Months 0 Days 5 If less than one day hr. min.

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

10. Usual occupation NIL

11. Industry or business CARMEN STREET

FATHER
12. Name DR. RUSSELL H. SPARKS
13. Birthplace KENTUCKY (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name ADELINE YARBROUGH
15. Birthplace KENTUCKY (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Carrie Sparks
(b) Address 4479 FOREST PARK BLV.

17. (a) BURIAL (Burial, ~~cremation, or removal~~) (b) Date thereof SEPT 15-47 (Month) (Day) (Year)
(c) Place: burial ~~or cremation~~ SUN SET BURIAL PARK

18. (a) Signature of funeral director E. J. Schnur.
(b) Address 3125 Lafayette Av.

19. (a) SEP 15 1947 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 12th year 1947 hour 7:00 minute P M.

21. I hereby certify that I attended the deceased from 8/7/47, 19, to Sept. 13th 19 47 that I last saw him alive on Sept. 13th 19 47 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pul TBC	3 yrs
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN

Underline the cause of which death should be charged statistically.

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature George P. Smith (Attorney or other)

Address 1515 Lafayette 9/13/47 Date signed

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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. 4014

P. O. Address 3125 Lafayette Ave.

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.