

STANDARD CERTIFICATE OF DEATH

4780

FILED MAR 1 1952

State File No. ....

BIRTH NO. .... REG. DIST. NO. 140 PRIMARY REG. DIST. NO. 3024 Registrar's No. 142

0451

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

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Howard</u>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Howell</u> |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Fayette, Mo.</u> |  | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>West Plains</u>   |  |
| c. LENGTH OF STAY (In this place) <u>7 Months</u>  |  | d. STREET ADDRESS (If rural, give location) <u>1</u>  |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>Lee Hospital</u>                                     |  |   |  |

|                                     |                           |                          |                         |  |
|-------------------------------------|---------------------------|--------------------------|-------------------------|--|
| 3. NAME OF DECEASED (Type or Print) | a. (First) <u>Frances</u> | b. (Middle) <u>Bunch</u> | c. (Last) <u>Sparks</u> | 4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 19, 1952</u> |
|-------------------------------------|---------------------------|--------------------------|-------------------------|--|

|                      |                               |   |                                   |   |  |   |
|----------------------|-------------------------------|---|-----------------------------------|---|--|---|
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u> | 8. DATE OF BIRTH <u>6/25/1867</u> | 9. AGE (In years last birthday) <u>84</u> | IF UNDER 1 YEAR Months <u>7</u> Days <u>24</u> | IF UNDER 11 HRS. Hours <u></u> Min. <u></u> |
|----------------------|-------------------------------|---|-----------------------------------|---|--|---|

|   |   |  |  |
|---|---|--|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>----</u> | 11. BIRTHPLACE (State or foreign country) <u>Clarksburg, Tenn. /</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
|---|---|--|--|

|   |  |  |
|---|--|--|
| 13a. FATHER'S NAME <u>Abner J. Gupton</u> | 13b. MOTHER'S MAIDEN NAME <u>Mary F. Crowe</u> | 14. NAME OF HUSBAND <del>OR WIFE</del> <u>Richard Alvin Sparks</u> |
|---|--|--|

|   |                                     |  |
|---|-------------------------------------|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u> | 16. SOCIAL SECURITY NO. <u>None</u> | 17. INFORMANT'S SIGNATURE OR NAME <u>Everett Buckner</u> ADDRESS <u>Fayette, Mo.</u> |
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| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION   |  | INTERVAL BETWEEN ONSET AND DEATH <u>7 months</u> |
|   | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) <u>Sub-Acute bilateral pyelonephritis</u>   |  |  |
|   | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last:<br><br>DUE TO (b) _____<br>DUE TO (c) _____ |  |  |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.   |   |  |  |

|                        |  |  |
|------------------------|--|--|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION <u>6000</u> | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|------------------------|--|--|

|  |  |   |
|--|--|---|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) |
|--|--|---|

|  |   |                            |
|--|---|----------------------------|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | 21f. HOW DID INJURY OCCUR? |
|--|---|----------------------------|

22. I hereby certify that I attended the deceased from July 1, 1950, to Feb 18, 1952, that I last saw the deceased alive on Feb 18, 1952, and that death occurred at 12:30 AM, from the causes and on the date stated above.

|   |   |                                 |
|---|---|---------------------------------|
| 23a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>M.D.</u> | 23b. ADDRESS <u>Lee Hospital Fayette, Mo.</u> | 23c. DATE SIGNED <u>2-19-52</u> |
|---|---|---------------------------------|

|  |                          |  |   |
|--|--------------------------|--|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 24b. DATE <u>2/19/52</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>West Plains Cemetery</u> | 24d. LOCATION (City, town, or county) (State) <u>West Plains Missouri</u> |
|--|--------------------------|--|---|

|   |  |   |
|---|--|---|
| DATE REC'D BY LOCAL REG. <u>2-19-52</u> | REGISTRAR'S SIGNATURE <u>Mary N. Shell</u> | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph A. Carr</u> ADDRESS <u>Fayette, Mo.</u> |
|---|--|---|

APR 12 1952

MAR 18 1952

**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 \_\_\_\_\_

working under my personal supervision.

Student Embalmer No. ....

Signed

*Ralph A. Carr*

Signed.....

Student Embalmer

Licensed Embalmer No. 3340

P. O. Address Fayette 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.