

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-022092  
STATE FILE NUMBER  
2751

FILED JUN 16 1958 Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

S. 300  
1-57

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kansas City</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Gen'l Hosp. #1</b>		Length of stay in 1b <b>38 yrs</b>	d. STREET ADDRESS (If outside, give location) <b>130 S. Lawn</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>E.</b> Last <b>Sproat</b>			4. DATE OF DEATH Month <b>5</b> Day <b>29</b> Year <b>1958</b>			
---	--	--	---	--	--	--

5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 14, 1897</b>	9. AGE (In years last birthday) <b>60</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
--------------------	-------------------------------	---	--	--	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Auto Assembly</b>	11. BIRTHPLACE (City and state or country) <b>Warrensburg, Mo</b>	12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>
---	---	--	--

13a. FATHER'S NAME <b>John T. Sproat</b>	13b. MOTHER'S MAIDEN NAME <b>Linnie McCurdy</b>	14. NAME OF HUSBAND OR WIFE <b>Zelma Sproat</b>
---	--	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>487-05-3305</b>	17. INFORMANT <b>Zelma Sproat</b> Address <b>Kansas City, Missouri</b>
--	---	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Encephalomalacia with recent cerebrovascular accident</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 3/4</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
---	--

20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
---	--	--	---

21. I attended the deceased from **May 21, 1958** to **May 29, 1958** and last saw <sup>him</sup> alive on **May 29, 1958**  
 Death occurred at **6:05A.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>B. Burns, M.D.</b>	22b. ADDRESS <b>24th &amp; Cherry</b>	22c. DATE SIGNED <b>5-29-58</b>
---	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>5-31-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Floral Hills Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Kansas City, Missouri</b>
--	-----------------------------	--	---

24. FUNERAL DIRECTOR <b>Stine &amp; McClure</b> ADDRESS <b>Kansas City, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>5-30-58</b>	26. REGISTRAR'S SIGNATURE <b>neva minshall</b>
--	--	---

All diseases in Part I must be causally related.  
 Only black ink or ribbon typewrite if possible.  
 B. I. BATES MEDICAL CERTIFICATION



**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 ....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed .....

Licensed Embalmer No.....

P. O. Address.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.