

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011733
STATE FILE NUMBER

WED APR 6 1959 Registration District No. 317 Primary Registration District No. 547 Registrar's No. 659

1. PLACE OF DEATH a. COUNTY ST. LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY 7	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN RICHMOND HEIGHTS		c. CITY OR TOWN ST. LOUIS	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. MARY'S HOSPITAL		d. STREET ADDRESS (If outside, give location) 1304 So 14th ST.	

3. NAME OF DECEASED (Type or print) First Middle Last JAMES LEE SPARKS SR			4. DATE OF DEATH Month Day Year MAR 10 1959		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAR 11 1898	9. AGE (In years last birthday) 60	10. UNDER 1 YEAR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAINTENANCE MAN BOYDS CLOTHING		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) MISSOURI		12. CITIZEN OF WHAT COUNTRY? U-S-A	
13a. FATHER'S NAME CYRUS S. SPARKS		13b. MOTHER'S MAIDEN NAME HATTEE GREEN		14. NAME OF HUSBAND OR WIFE BESSIE SPARKS			

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 499-01-3473		17. INFORMANT Address BESSIE SPARKS 1304 So 14th ST.			
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Wrenuc myocarditis			INTERVAL BETWEEN ONSET AND DEATH 2
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Pylonephritis -			
DUE TO (c) 600.0			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) X			
20c. TIME OF INJURY Hour Month, Day, Year a.m. X p.m.			20d. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office, pdg., etc.) X			
20e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			20f. CITY, TOWN, OR LOCATION COUNTY STATE X			

21. I attended the deceased from **1957** to **3/10/59** and last saw him alive on **3/10/59**.
Death occurred at **810 A.** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) John C. Murphy M.D.		22b. ADDRESS 4101 Lundeel Blvd		22c. DATE SIGNED 3/12/59	
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-13-59		23c. NAME OF CEMETERY OR CREMATORY Lakewood Park		23d. LOCATION (City, town, or country) (State) St. Louis Co. Mo.	
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24. FUNERAL DIRECTOR Thomas Kuts 2906 Gravois		25. DATE RECD. BY LOCAL REG. 3-12-59		26. REGISTRAR'S SIGNATURE John C. Murphy M.D.	
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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

11-1
6161-5-70
by me

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 *Eleanore Province*

Licensed Embalmer No. *3403*
P. O. Address *Jennings*

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.