

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011893
STATE FILE NUMBER

FILED APR 14 1959

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 945

300
-57

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Rural Wellston		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Chesterfield Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Vincent's Hosp.		Length of stay in lb 2yrs. 6mos.	d. STREET ADDRESS (If outside, give location) Box 762 Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First WANDA Middle HALLIE Last SPARKS			4. DATE OF DEATH Month April Day 6 Year 1959		
5. SEX Female	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. 15, 1896		9. AGE (In years last birthday) 63 IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY HOME	11. BIRTHPLACE (City and state or country) Carrolton, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Gershon Herriot		13b. MOTHER'S MAIDEN NAME Daisy M. Smith		14. NAME OF HUSBAND OR WIFE Robert 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. No	17. INFORMANT Robert Sparks, husband Address Box 762 Chesterfield, Missouri		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Pneumonia		INTERVAL BETWEEN ONSET AND DEATH 5 days	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Generalized Arteriosclerosis		Years
	DUE TO (c) Generalized Osteoarthritis		Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4500		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

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 Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <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 Oct. 6, 1956 to April 6, 1959 and last saw her alive on April 6, 1959
Death occurred at 10:55 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>W B Lytton</i> (Degree or title)	22b. ADDRESS 7301 St. Charles Rock Rd.	22c. DATE SIGNED 4/7/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 4-9-59	23c. NAME OF CEMETERY OR CREMATORY Resurrection Cem.	23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.
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24. FUNERAL DIRECTOR Schraier F. H., Baldwin, Mo.	25. DATE RECD. BY LOCAL REG. 4-7-59	26. REGISTRAR'S SIGNATURE John C. Murphy M.D.
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

1959 AUG 7

AUG 10 1959

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 *Richard Bopp*

Licensed Embalmer No. *4584*
P. O. Address *Baltimore, Md.*

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.