

**FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-038102**

**FILED VS OCT 23 1959**

**2 9410**

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's \_\_\_\_\_

<b>1. PLACE OF DEATH</b> a. COUNTY _____ b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b> Length of stay in 1b _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Homer G. Phillips</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY _____ c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <b>1413 N. Sarah</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>				
<b>3. NAME OF DECEASED</b> (Type or print) First <b>John</b> Middle _____ Last <b>Sparks</b>		<b>4. DATE OF DEATH</b> Month <b>10</b> Day <b>8</b> Year <b>59</b>				
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>Negro</b>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input checked="" type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>11/28/32</b>	<b>9. AGE (last birthday)</b> <b>26</b>	<b>IF UNDER 1 YEAR</b> Months _____ Days _____	<b>IF UNDER 24 HR</b> Hours _____ Min. _____
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> _____		<b>11. BIRTHPLACE</b> (City and state or country) <b>St. Louis, Missouri</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U. S. A.</b>
<b>13a. FATHER'S NAME</b> <b>Richard Sparks</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>Rosa Lee Williams</b>		<b>14. NAME OF HUSBAND OR WIFE</b> _____		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>	<b>17. INFORMANT</b> Address <b>Rosa Lee Williams, 4718 Maffitt</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypoglycemic Encephalopathy</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <b>Undet.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Diabetes Mellitus 260x</b>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.) _____				
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>				
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>9-6-59</b>		<b>20f. CITY, TOWN, OR LOCATION</b> <b>10-8-59</b>		<b>COUNTY</b> _____	<b>STATE</b> _____	
<b>21. I attended the deceased from</b> <b>7:25</b> <b>to</b> <b>10-8-59</b> <b>and last saw him</b> <b>alive on</b> <b>10-8-59</b> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.						
<b>22. SIGNATURE</b> (Degree or title) <i>Edward R. Williams</i>			<b>22b. ADDRESS</b> <b>2601 N. Whittier St.</b>		<b>22c. DATE SIGNED</b> <b>10-8-59</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>	<b>23b. DATE</b> <b>8/14/59</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <del>_____</del>		<b>23d. LOCATION</b> (City, town, or county) (State) <b>St. Louis Co., Mo</b>		
<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>Green Funeral Home, 4060 Washington Ave</b>		<b>25. DATE RECD. BY LOCAL REG.</b> <b>OCT 14 '59</b>	<b>26. REGISTRAR'S SIGNATURE</b> <i>Earl Smith, M.D.</i> _____			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 Melvin E. Green

Licensed Embalmer No. 4428

P. O. Address St. Louis

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.