

**JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**  
**FILED VS JUL 1 1960**

**-60-024993**

**318**

**1003**

**6388**

STATE FILE NUMBER

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

<b>1. PLACE OF DEATH</b> a. COUNTY		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Mo.</b>	Length of stay in 1b	c. CITY OR TOWN <b>ST. LOUIS, MO</b>	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Louis City Hosp. #1</b>		d. STREET ADDRESS <b>1112 COLE</b>	(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>Baby Boy Sparks</b>			<b>4. DATE OF DEATH</b> Month Day Year <b>6 19 60</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>6/18/60</b>	<b>9. AGE</b> (last birthday)	<b>IF UNDER 1 YEAR</b> Months Days <b>9 5</b>	<b>IF UNDER 24 HR</b> <b>5</b>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most working life, even if retired) <b>NONE</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>NONE</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>ST. LOUIS, MO</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.A.</b>

<b>13a. FATHER'S NAME</b> <b>CLARENCE EUGENE SPARKS</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>ROSEA MAE SADDLER</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>ST. LOUIS CITY HOSP. #1.</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>atelectasis</b> <b>wt 2125 gm</b>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c) <b>762.0</b>	

<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH</b> but not related to the terminal disease condition given in PART I (a)		<b>PART III. If deceased was female was there a pregnancy in last 90 days.</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input 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.	<b>Month, Day, Year</b>		
<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>20f. CITY, TOWN, OR LOCATION</b>	<b>COUNTY</b> <b>STATE</b>

**21. I attended the deceased from** **6-18-60**, to **6-19-60** and last saw him alive on **6-19-60**  
 Death occurred at **6:55 A** m on the date stated above, and to the best of my knowledge, from the causes stated.

<b>22a. SIGNATURE</b> <i>Wilma Caseman, M.D.</i>	(Degree or title)	<b>22b. ADDRESS</b> <b>155 Lafayette Ave.</b>	<b>22c. DATE SIGNED</b> <b>6-19-60</b>
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<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)	<b>23b. DATE</b> <b>6-30-60</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Anatomical Board</b>	<b>23d. LOCATION</b> (City, town, or county) (State) <b>St. Louis, Mo.</b>
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<b>24. FUNERAL DIRECTOR</b> <b>Rowland Mortuary Svc. 4104-06 Manchester</b>	<b>25. DATE RECD. BY LOCAL REG.</b> <b>JUN 23 1960</b>	<b>26. REGISTRAR'S SIGNATURE</b> <i>Loan Smith, M.D.</i>
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BY-AFFIDAVIT OF DOCUMENT 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  
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 do so 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.