

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-014534

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 65 Primary Registration District No. _____ Registrar's No. 11

FILED APR 23 1962

VS 300
Rev. 4/59

1 0210
2 0810
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1290-2
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>Chariton</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Chariton</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Salt Creek</u>		Length of stay in 1b <u>53 yrs</u>	c. CITY OR TOWN <u>Marceline</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>R.F.D. 1</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>R.F.D. 1</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Edith E. Sparks</u>			4. DATE OF DEATH Month Day Year <u>April 14, 1962</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2/14/1890</u>
9. AGE (last birthday) <u>72</u>		IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u>	IF UNDER 24 HR Hours <u>76</u> Min. <u>15</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Kansas</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>Ben. Helm</u>	
13b. MOTHER'S MAIDEN NAME <u>Fannie Sharp</u>		14. NAME OF HUSBAND OR WIFE <u>Clarence</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	17. INFORMANT Address <u>Paul Sparks Marceline, Mo.</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO (b) <u>Series of Acute Cerebral Accidents</u> DUE TO (c) <u>Hypertensive Heart Disease and Generalized atherosclerosis.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>76 hrs.</u> <u>76 hrs.</u> <u>15 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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 <u>1 p.m. July 13, 1953</u>		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>Brookfield, Mo.</u>	
21. I attended the deceased from <u>July 13, 1953</u> to <u>April 14, 1962</u> last saw her alive on <u>4/14/62</u> Death occurred at <u>1 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Dated or filed) <u>John W. White, D. O.</u>		22b. ADDRESS <u>Brookfield, Mo.</u>	22c. DATE SIGNED <u>4/14/62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>	23b. DATE <u>4/16/1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Saloem</u>	23d. LOCATION (City, town, or county) (State) <u>Mendon, Mo</u>
24. FUNERAL DIRECTOR ADDRESS <u>James McLaughlin Marceline, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>Apr 18-1962</u>	26. REGISTRAR'S SIGNATURE <u>Dovie Smith</u>

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 Gerald T. Wade

Licensed Embalmer No. 4172

P. O. Address Crowney

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.