

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATHState File No. 44409

MAY 13 1940

Registration District No. 735Primary Registration District No. 3034Registrar's No. 234

## 1. PLACE OF DEATH:

- (a) County Randolph 2  
 (b) City or town Moberly  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
320 No 4th St  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
 (Specify whether

In this community \_\_\_\_\_  
years, months or days)3. (a) PRINT FULL NAME Mollie Sparkman 162

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married6. (b) Name of husband or wife Sam Sparkman 6. (c) Age of husband or wife if alive \_\_\_\_\_ years7. Birth date of deceased Feb 27th 1869  
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day  
70 6 14 \_\_\_\_\_ hr. \_\_\_\_\_ min.9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) Mo10. Usual occupation At home

11. Industry or business \_\_\_\_\_

12. Name James T. Melone 013. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) Va14. Maiden name Nancy J. King15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) Mo16. (a) Informant's own signature Sam Sparkman(b) Address Moberly17. (a) \_\_\_\_\_ (b) Date thereof Dec 13th 1939  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Moberly18. (a) Signature of funeral director Mahan and Son(b) Address Moberly Mo19. (a) Dec 13 '39 (b) Peak Halliday  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County Randolph  
 (c) City or town Moberly  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 320 No 4th  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 11th  
year 1939 hour 8 minute 25 a.m.21. I hereby certify that I attended the deceased from Nov  
26th, 1939 to Dec 11th, 1939that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_

Due to Refractory Sepsis 10/11/39  
Do not know 1/11/39

Due to \_\_\_\_\_

Other conditions no  
(Include pregnancy within 3 months of death) 12/1Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_Of autopsy no

## PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide (specify) no  
 (b) Date of occurrence \_\_\_\_\_  
 (c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? no (Specify type of place) (e) Means of injury \_\_\_\_\_23. Signature Peak Halliday (M. D. or other) 1  
Address Moberly Mo Date signed 12/11/39

RECEIVED

District Health Officer No. 10

District File Number 1-40-157

Date Filed JAN 11 1940

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.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed Frank D. Hunt

Licensed Embalmer No. 3021

P. O. Address Moberly Mo

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 this body is not embalmed, above space should be left blank.