

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **33237**  
Registrar's No. **137**

Registration District No. **7 246** Primary Registration District No. **3038**

1. PLACE OF DEATH:  
(a) County Saline  
(b) City or town Marshall  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:

(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 James Wesley Sparks  
3. (b) If veteran, name war ✓  
3. (c) Social Security No. ✓

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Frances M. Sparks  
6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased May 12 1865  
(Month) (Day) (Year)

8. AGE: Years 75 Months 5 Days 23  
If less than one day hr. min.

9. Birthplace Bowling Co. Ky.  
(City, town, or county) (State or foreign country)

10. Usual occupation City Mayor

11. Industry or business

MOTHER FATHER { 12. Name John Wesley Sparks

13. Birthplace Ky.  
(City, town, or county) (State or foreign country)

14. Maiden name Julia Garrison

15. Birthplace Ky.  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Wallace R. Wingfull

(b) Address Marshall, Mo.

17. (a) Burial (b) Date thereof Sept. 8 - 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bridge Park Cem.

18. (a) Signature of funeral director Central Lumber  
(b) Address Marshall, Mo.

19. (a) 9-7-40 (b) Mary Kent  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Saline

(c) City or town Marshall  
(If outside city or town limits, write "RURAL")

(d) Street No. 201 East Ninth St.  
(If rural, give location)

(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 5 year 1940 hour 11 minutes 45 P.

21. I hereby certify that I attended the deceased from 10 to 5 1940  
that I last saw him alive on Sept 5 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage  
Due to \_\_\_\_\_

Due to Hypertension

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations g20  
Of autopsy a

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

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(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? 7/2

While at work \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
Address [Address] Date signed 9/6/40

Duration

2 yrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED  
District Health Officer No. 8,  
District File Number  
Date Filed 10-12-40

**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.....

*R.W. Campbell*..... Registered Apprentice No.....  
working under my personal supervision.

Signed..... *R.W. Campbell*  
Licensed Embalmer No. *3469*  
P. O. Address *Marshall, W.V.*

**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.**