

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1119 Troost Ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 5 Weeks
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 1119 Troost Ave.
(If rural, give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Mrs Sarah A. Sparr

3. (b) If veteran, name war No 3. (c) Social Security No. None

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

6. (b) Name of husband or wife Frank Sparr 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Feb. 13, 1867
(Month) (Day) (Year)

8. AGE: Years 77 Months 0 Days 18 If less than one day hr. _____ min. _____

9. Birthplace Jefferson City, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business _____

MOTHER FATHER
12. Name No record
13. Birthplace No record (City, town, or county) (State or foreign country)
14. Maiden name No record
15. Birthplace No record (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Chas. H. Becker

(b) Address 1119 Troost Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof March 4, 1944
(Month) (Day) (Year)

(c) Place: burial or cremation Elmwood

18. (a) Signature of funeral director Thos. E. Quirk Funeral Home

(b) Address 4316 Troost Ave.

19. (a) 3-3-44 (Date received local registrar) (b) N. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 1st year 1944 hour 10 A.M. Minute _____ M.

21. I hereby certify that I attended the deceased from Jan 26, 1944 to March 1, 1944
that I last saw her alive on Feb 16, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death coronary insufficiency Duration 9 weeks
Due to chronic myocarditis 2 yr
Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations 930 Of autopsy _____
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) _____
(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? _____ (Specify type of place) (e) Means of injury _____

23. Signature George H. Newland (M. D. or other) MD
Address Kansas City, Mo Date signed 3-2-44

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

Thomas E. Zwick

Licensed Embalmer No. *3775*

P. O. Address *A. C. 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, fact should be so stated above.