No. 2
-8-43
-17-39
X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 28 1944

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 28844

Registration District No. 317 Primary Registration District No. 6076 Registrar's No. 1765

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Jefferson Barracks (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Veterans' Administration Facility, (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Adm. Aug. 13, 1944 (Specify whether
In this community Since August 13, 1944. years, months or days)

2. USUAL RESIDENCE OF DECEASED: 999

(a) State Illinois (b) County Madison
(c) City or town Nameoki (If outside city or town limits, write "RURAL")
(d) Street No. 3831 Nameoki Road. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country - - - 2

3. (a) PRINT FULL NAME SPARKS, Lee J.
3. (b) If veteran, name war W.W. #1
3. (c) Social Security No. 708-09-4671
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of ~~husband~~ wife Mrs. Martha Sparks,
6. (c) Age of ~~husband~~ wife if alive 39 years
7. Birth date of deceased April 19, 1890 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	54	3	28	hr. - min.

9. Birthplace Poag, Illinois. (City, town, or county) (State or foreign country)
10. Usual occupation Railroad Engineer,
11. Industry or business - - -
FATHER
12. Name Augustus Sparks,
13. Birthplace Unavail. (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Mary Smith,
15. Birthplace Unavail. (City, town, or county) (State or foreign country)
16. (a) Informant M. Schilly Cl.Clk.,
(b) Address Vets.Adm.Fac., Jeff.Brks., Mo.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Aug 18 1944 (Month) (Day) (Year)
(c) Place: burial or cremation Wanda Cemetery
18. (a) Signature of funeral director Charles E Mercer
(b) Address 1416 Meadinghaus Ave Granite City, Ill.
19. (a) AUG 28 1944 (Date received local registrar) (b) C. S. McGarvey, M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 17th year 1944 hour 7:40 minute PM. M.
21. I hereby certify that I attended the deceased from August 13, 1944 to August 17, 1944; that I last saw him alive on August 17, 1944; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death HEMORRHAGE, INTRA AND EXTRA-CRANIAL TRAUMATIC.	UNKN.
OTHER CONDITIONS: -	
~~xxxx~~ FRACTURE OF SKULL, RIGHT, PARIETAL RECENT, COMMINUTED.	UNKN.
~~xxx~~ PNEUMONIA, LOBULAR, LOWER LOBES, BILATERAL.	2-days.
~~Other conditions~~ (Include pregnancy within 3 months of death)	

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Major findings: Of operations No Operation
Of autopsy ~~No~~ Autopsy, performed, - See Cause of death.

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) accident 136
(b) Date of occurrence 8-13-44
(c) Where did injury occur? Granite City, Ill. (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Granite City, Ill. ~~home~~ indefinite (Specify type of place)
While at work? (e) Means of injury
23. Signature W.R. GERMAN, M.D., (M. D. or other) 8-18-1944
Address Chief Medical Officer, Jefferson Barracks, Mo. Date signed

(Licensed Embalmer's Statement on Reverse Side)

SEP 18 1944

SEP 19 1944

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 Charles C Mercer

Licensed Embalmer No. 2988

P. O. Address Granite City Ill

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.

No. 2B
M—5-43
P I X36930

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BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Sept

Registration District No. 317 Primary Registration District No. 6076 Registrar's No. 1765

1. PLACE OF DEATH:

(a) County St Louis

(b) City or town Jefferson Barracks
(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 years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

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

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Sparks, Lee J.

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased April 19 1898
(Month) (Day) (Year)

8. AGE: Years 54 Months 3 Days 28 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

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

14. Maiden name

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. Day 17 year 1944 hour 7:40 minute P. M.

21. I hereby certify that I attended the deceased from Aug. 13, 1944 to August 17, 1944 that I last saw him alive on August 17, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
HEMORRHAGE, INTRA AND EXTRA-CRANIAL, TRAUMATIC.	Unknown
OTHER CONDITIONS:	
FRACTURE OF SKULL, RIGHT, PARIETAL RECENT, COMMINUTED.	Unknown
PNEUMONIA, LOBULAR, LOWER LOBES, BILATERAL.	2-days

(Include pregnancy within 3 months of death)

Major findings:
Of operations None.
Of autopsy Autopsy performed - See cause of death.

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, (specify) Yes

(b) Date of occurrence

(c) Where did injury occur? Rooming House
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)

While at work? (e) Means of injury Fall downstairs.

23. Signature W. A. GERMAN, M.D. (M. D. or other)

Address Chief Medical Officer Date signed 8/18/44

SUPPLEMENTARY

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

28844