S. No. 2
DM—5-43
v. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED APR 17 1946

State File No. 13533

Registration District No. 150

Primary Registration District No. 5572

Registrar's No. 3

1. PLACE OF DEATH:

(a) County Jackson,

(b) City or town ~~[illegible]~~ Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Jackson County Emergency Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution no. (Specify whether
In this community 6 months
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson, 48

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

(d) Street No. 0
(If rural, give location)

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

If yes, name country x

3. (a) PRINT FULL NAME James E. Sparks

3. (b) If veteran, name war no.

3. (c) Social Security No. no.

4. Sex male

5. Color or race white

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

6. (b) Name of husband or wife Hattie Bell Sparks

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

7. Birth date of deceased October (Month) 23 (Day) 1865 (Year)

8. AGE:

Years	Months	Days	If less than one day
80	2	15	hr. min.

9. Birthplace Ohio (City, town, or county) 1 (State or foreign country)

10. Usual occupation Retired

11. Industry or business x

FATHER
12. Name John Sparks
13. Birthplace unknown, (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name Artie Lindsey
15. Birthplace unknown, (City, town, or county) 9 (State or foreign country)

16. (a) Informant William Bishop, 1
(b) Address Grandview, Missouri

17. (a) removal (Burial, cremation, or removal) (b) Date thereof 1-8-46 (Month) (Day) (Year)
(c) Place: burial or cremation Avalon, Missouri

18. (a) Signature of funeral director Stine & McClure,
(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) 1/8/46 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 6th year 1946 hour 2:15 minute P. M.

21. I hereby certify that I attended the deceased from Coroner, 19..., to ..., 19...; that I last saw h... alive on ..., 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Coronary schemes	
Due to Arterio schemes	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations 9/4
Of autopsy no
Hurley & Turpetino

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

23. Signature [signature] (M.D. or other) 2 Carr
Address 1424 [illegible] Date signed 1-8-46

133 (Licensed Embalmer's Statement on Reverse Side)

MAY 27 1945

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 Robert H Reed

Licensed Embalmer No. 3745

P. O. Address K 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.