

FILED OCT 3 1949

STANDARD CERTIFICATE OF DEATH

State File No. 29550

BIRTH NO. _____ REG. DIST. NO. 53 PRIMARY REG. DIST. NO. 301e Registrar's No. 318

1. PLACE OF DEATH a. COUNTY Cape Girardeau		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Pemiscot 7X	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Cape Girardeau		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Steele (Rural)	
c. LENGTH OF STAY (In this place) 1 day		d. STREET ADDRESS (If rural, give location) R. F. D. #2	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Francis 11			

3. NAME OF DECEASED a. (First) Wanda		b. (Middle) Marie		c. (Last) Sparks		4. DATE OF DEATH (Month) (Day) (Year) Sept 20, 49		
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married	8. DATE OF BIRTH Dec. 22, 1948	9. AGE (In years last birthday) -	10. MONTHS 8	11. DAYS	12. HOURS 0	13. MINUTES 0
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) New Madrid, Mo. 0	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Leo Sparks	13b. MOTHER'S MAIDEN NAME Lena Dewrock	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Lena Sparks Steele, Mo.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>HE. ENTERITIS</u>		
ANTECEDENT CAUSES		DUE TO (b)	
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (c)	
II. OTHER SIGNIFICANT CONDITIONS		5710	
Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR
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22. I hereby certify that I attended the deceased from 8/18, 1949 to 8/20, 1949, that I last saw the deceased alive on 8/20, 1949, and that death occurred at 8:20 p.m., from the causes and on the date stated above.

23a. SIGNATURE C. L. Smith (Signature or title)	23b. ADDRESS 11 West Cape Girardeau, Mo.	23c. DATE SIGNED 9/21/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 9/22/49	24c. NAME OF CEMETERY OR CREMATORY Lorimier Cemetery	24d. LOCATION (City, town, or county) (State) Cape Girardeau, Mo.
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DATE REC'D BY LOCAL REG. 9-22-1949	REGISTRAR'S SIGNATURE C. B. Summers 44	25. FEDERAL DIRECTOR'S SIGNATURE ADDRESS C. J. Loberg Cape Girardeau, Mo.
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(Licensed Embalmer's Statement of Reverse Side)

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

No. 300
10-48
16

RECEIVED 9-26-49
Health Officer No. 4
File Number 249-12
Date

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 _____

working under my personal supervision. _____ Student Embalmer No. _____

Student
Student Embalmer

Signed *[Signature]* _____
Licensed Embalmer No. 3810
P. O. Address Cape Girardeau, 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.