

FILED SEP 14 1950

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. 27478

BIRTH NO. 29102-50 REG. DIST. NO. 187 PRIMARY REG. DIST. NO. 9840 Registrar's No. 135

1. PLACE OF DEATH a. COUNTY <u>Livingston</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Livingston</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Chillicothe</u>		c. LENGTH OF STAY (in this place) <u>4 months</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>324 Madison</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Chillicothe</u>	
		d. STREET ADDRESS (If rural, give location) <u>324 Madison</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Penny</u> b. (Middle) <u>Love</u> c. (Last) <u>Sparks</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>7-24-50</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never Married-1</u>	8. DATE OF BIRTH <u>3-10-50</u>
9. AGE (In years last birthday) <u>4</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>	11. BIRTHPLACE (State or foreign country) <u>Chillicothe, Missouri</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND-OF-BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13a. FATHER'S NAME <u>W^m Earl Sparks</u>		13b. MOTHER'S MAIDEN NAME <u>Mary K. Gish</u>	14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	17. INFORMANT'S SIGNATURE OR NAME <u>W^m Earl Sparks; Chillicothe, Missouri</u> ADDRESS
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Malnutrition</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>Inadequate feeding</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>	
		INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u> <u>4 months</u> <u>7720</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
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)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>23 July, 1950</u> , to <u>24 July, 1950</u> , that I last saw the deceased alive on <u>23 July, 1950</u> , and that death occurred at <u>5:00 p.m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>Charles M. Grace, M.D.</u> (Degree or title)		23b. ADDRESS <u>Chillicothe, Mo.</u>	
23c. DATE SIGNED <u>30 July 1950</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>7-25-50</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>Edgewood</u>		24d. LOCATION (City, town, or county) (State) <u>Chillicothe, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>Aug 2-50</u>		REGISTRAR'S SIGNATURE <u>Frances B. Neill</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Norman Funeral Home; Chillicothe, Mo</u>		ADDRESS	

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

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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.

Signed _____

Joseph M. Gibson

Signed _____
Student Embalmer

Licensed Embalmer No. 4769

P. O. Address Chillicothe, 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.