

FILED MAR 22 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **8424**

BIRTH NO. **15013-55** REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002** Registrar's No. **965**

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY OR TOWN Kansas City		c. CITY OR TOWN Kansas City	
c. LENGTH OF STAY (in this place) Life		d. FULL NAME OF HOSPITAL OR INSTITUTION Children's Mercy Hospital	
d. FULL NAME OF HOSPITAL OR INSTITUTION		e. STREET ADDRESS (If rural, give location) 4911 E. 27th Street	

3. NAME OF DECEASED (Type or Print) a. (First) Stephen	b. (Middle)	c. (Last) Sparks	4. DATE OF DEATH (Month) (Day) (Year) 3-2-55
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5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) child	8. DATE OF BIRTH Feb. 14, 1955	9. AGE (In years last birthday) 18	IF UNDER 1 YEAR Months — Days — Hours — Min. —	IF UNDER 24 HRS. Hours — Min. —
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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 child	11. BIRTHPLACE (City and State or Foreign Country) Kansas City, Missouri	12. CITIZENRY OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME unknown	13b. MOTHER'S MAIDEN NAME Jeanette Sparks	13c. NAME OF HUSBAND OR WIFE child
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Farmout Hospital, 4911 E. 27th, K.C. Mo.	ADDRESS
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) SEPTICEMIA - dehydration			

ANTECEDENT CAUSES		DUE TO (b) CELLULITIS OF LEFT SCAPULAR REGION - probably from wounds.	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (c) patent foramen ovale + pneumonia	

II. OTHER SIGNIFICANT CONDITIONS ASCITES, PULMONARY CONGESTION		7543
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19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **3-1-**, 19**55**, to **3-2**, 19**55**, that I last saw the deceased alive on **3-2-**, 19**55**, and that death occurred at **1:55** p.m., from the causes and on the date stated above.

23a. SIGNATURE Wayne Hart (Degree or title) MD	23b. ADDRESS Mercy Hospital	23c. DATE SIGNED 3-2-55
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 3-4-55	24c. NAME OF CEMETERY OR CREMATORY Green Lawn	24d. LOCATION (City, town, or county) (State) Jackson Co MO
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DATE REC'D BY LOCAL REG. 3-3-55	REGISTRAR'S SIGNATURE Neve Marshall	25. FUNERAL DIRECTOR'S SIGNATURE France-Wornall Funeral Home	ADDRESS KE MO
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WRITE PLAINLY—USING UNFAADING 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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Russell N. Fran*.....

Licensed Embalmer No. *42*
P. O. Address *Ke-*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.