Health, Welfare Public Service

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FILED OCT 7 1957

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

30944
STATE FILE NUMBER

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1029

1. PLACE OF DEATH
a. COUNTY Buchanan
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) St. Joseph — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 3023 Angelique — Length of stay in 1b: 5 yrs

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Buchanan
c. CITY OR TOWN St. Joseph — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 3023 Angelique — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First JOHN Middle C. Last SPRAKE

4. DATE OF DEATH Month Sept. Day 23, Year 1957

5. SEX Male

6. COLOR OR RACE White

7. MARRIED [ ] **NEVER MARRIED** [ ] **WIDOWED** [X] **DIVORCED** [ ]

8. DATE OF BIRTH Feb. 24, 1873

9. AGE (In years last birthday) 84 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer

10b. KIND OF BUSINESS OR INDUSTRY General Farming

11. BIRTHPLACE (City and state or country) DeKalb, Mo.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME James T. Sprake

13b. MOTHER'S MAIDEN NAME Belle Davis

14. NAME OF HUSBAND OR WIFE Dolly Sprake

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT Address Mrs. Kenneth Boyle 3023 Angelique City

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 24 hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Hemorrhagic diathesis - Type Undetermined — 4 months
DUE TO (c)
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 296 X

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 7-5-57 to 9-23-57 and last saw her/him alive on 9-23-57
Death occurred at 4:30 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Lucien N. Dale (Degree or title) M.D.

22b. ADDRESS 902 Edmond St. Joseph, Mo.

22c. DATE SIGNED 9-24-57

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE Sept. 25, 57

23c. NAME OF CEMETERY OR CREMATORY Sugar Creek Cemetery

23d. LOCATION (City, town, or county) (State) Buchanan County, Mo.

24. FUNERAL DIRECTOR Clark Funeral Home ADDRESS St. Joseph, Mo.

25. DATE RECD. BY LOCAL REG. Sept 30 1957

26. REGISTRAR'S SIGNATURE Mrs. Robert Fulton

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 Emma Clark

Licensed Embalmer No. 4235

P. O. Address St. Joseph

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.