Health, & Welfare Public Service

S. 300
1-57

FILED MAR 5 - 1958

THE DIVISION OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

58-007844
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2252

1. PLACE OF DEATH
a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI — Inside Limits Yes ☑ No ☐

c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) BARNES HOSPITAL — Length of stay in lb 1 Mo

04

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY ~~St Louis~~

c. CITY OR TOWN St Louis — Inside Limits Yes ☑ No ☐

d. STREET ADDRESS (If outside, give location) 4953 Washington — Reside on Farm Yes ☐ No ☒

2129

3. NAME OF DECEASED (Type or print) First ETHEL Middle E. Last SPARKS

4. DATE OF DEATH Month FEBRUARY Day 24, Year 1958

5. SEX Female

6. COLOR OR RACE White

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH May 3 - 1903

9. AGE (In years last birthday) 54 — 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) Housewife

10b. KIND OF BUSINESS OR INDUSTRY At Home

11. BIRTHPLACE (City and state or country) Hardin, Illinois

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

13a. FATHER'S NAME Samuel Newman

13b. MOTHER'S MAIDEN NAME Fannie Floyd

14. NAME OF HUSBAND OR WIFE Willie L. Sparks

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. Unknown

17. INFORMANT Walter Mefford Address 4953 Washington

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) MALIGNANT MELANOMA — INTERVAL BETWEEN ONSET AND DEATH 3 YEARS

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)

DUE TO (c) 190.9

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

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 JAN. 24, 1958, to FEB. 24, 1958 and last saw her/him alive on FEB. 24, 1958
Death occurred at 6:15 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) C. C. Vermillion, M.D. M. D.

22b. ADDRESS BARNES HOSPITAL

22c. DATE SIGNED 2/25/58

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

23b. DATE 2-25-58

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county) Jerseyville (State) Ill.

24. FUNERAL DIRECTOR Jacobi Bros. ADDRESS Jerseyville Ill.

25. DATE RECD. BY LOCAL REG. FEB 25 '58

26. REGISTRAR'S SIGNATURE J. Earl Smith, M.D. M.J.B.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. 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 Frank Prokopf

Licensed Embalmer No. 4356

P. O. Address St. Louis 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.