

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-026268
STATE FILE NUMBER

FILED JUL 25 1958

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 245

300
1-57
0

1. PLACE OF DEATH a. COUNTY <u>Marion</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Marion</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hannibal</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Hannibal</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Levering Hosp.</u>		Length of stay in lb <u>Life</u>	d. STREET ADDRESS (If outside, give location) <u>2900 Pleasant St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>HARRIET ALBERTA SPARKS</u>			4. DATE OF DEATH Month Day Year <u>7 - 9 - 58</u>		
---	--	--	---	--	--

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 22, 1889</u>	9. AGE (In years last birthday) <u>68</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
-------------------------	----------------------------------	---	--	--	---	--------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and state or country) <u>Hannibal, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
---	--	--	---

13a. FATHER'S NAME <u>Norman Albert Williams</u>	13b. MOTHER'S MAIDEN NAME <u>Anna Mary Dreyer</u>	14. NAME OF HUSBAND OR WIFE <u>E.L. Sparks</u>
---	--	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. -----	17. INFORMANT <u>E.L. Sparks, 2900 Pleasant St.,</u> Address <u>Hannibal, Mo.</u>
--	----------------------------------	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u>
DUE TO (b) <u>5721</u>		
DUE TO (c) <u>Post Operative Heart Death</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Laparotomy for diverticulitis Colon + Perforation</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
---	--

20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	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 <u>7-6-58</u> to <u>7-9-58</u> and last saw her alive on <u>7-9-58</u> Death occurred at <u>9:20p</u> m on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE (Degree or title) <u>W. H. Ardery M.D.</u>	22b. ADDRESS <u>Hannibal Mo</u>	22c. DATE SIGNED <u>7-15-58</u>
--	------------------------------------	------------------------------------

23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>7-11-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Grandview Burial Park</u>	23d. LOCATION (City, town, or county) (State) <u>Hannibal, Mo.</u>
---	-----------------------------	--	---

24. FUNERAL DIRECTOR <u>Jack Selway - Hannibal Mo</u> ADDRESS	25. DATE RECD. BY LOCAL REG. <u>7-18-58</u>	26. REGISTRAR'S SIGNATURE <u>Dr. E. M. Luske, By W. C. Fisher</u>
---	--	--

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

99
6

RECEIVED JUL 24 1958
MARION CO. HEALTH DEPT
DATE FILED JUL 24 1958

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 Jack Stewart

Licensed Embalmer No. 4900

P. O. Address Hornville, Va

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.