

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-044861

STATE FILE NUMBER

JAN 13 1959

Registration District No.

700

Primary Registration District No.

3041

Registrar's No.

6

300  
1-57

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <b>Macon</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Shelby</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Macon</b>		c. CITY OR TOWN <b>Lentner Twsp 1120</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Samaritan Hosp.</b>		d. STREET ADDRESS (If outside, give location) <b>3 Miles North of Lentner</b>	
Length of stay in 1b <b>5 Days</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>Belle</b> Last <b>Sparks</b>			4. DATE OF DEATH Month <b>Dec.</b> Day <b>27</b> Year <b>1958</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 2, 1887</b>
9. AGE (In years last birthday) <b>71</b>		IF UNDER 1 YEAR Months <b>7</b> Days <b>11</b>	IF UNDER 24 HRS. Hours <b>11</b> Min. <b>20</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (City and state or country) <b>Shelby County, Missouri</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>Charles L. Carroll</b>	
13b. MOTHER'S MAIDEN NAME <b>Hattie B. Taylor</b>		14. NAME OF HUSBAND OR WIFE <b>James B. Sparks</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>486 42 1856 B</b>	
17. INFORMANT <b>Mr. James Sparks, Lentner, Mo.</b>		Address <b>RFD</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Neurorrhage</b>			INTERVAL BETWEEN ONSET AND DEATH <b>6 days.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Hypertension</b>			331x
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Previous Cerebral Neurorrhage 7 Mo ago</b>			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 <b>Dec 23-58</b> to <b>Dec 27-58</b> and last saw her alive on <b>Dec 27-1958</b> Death occurred at <b>2:45 P.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Howard Miller MD</b>		22b. ADDRESS <b>Macon Mo</b>	
22c. DATE SIGNED <b>1-2-59</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12/29/1958</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Bacon Chapel Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Shelby County, Missouri</b>	
24. FUNERAL DIRECTOR <b>Hayes Funeral Home, Shelbina, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>1/7/59</b>	
26. REGISTRAR'S SIGNATURE <b>Cuth M. Sweeney</b>			

All diseases in Part I must be causally related.

APR 19 1961

Date Filed 7-12-61

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 *Paul E Hayes* .....

Licensed Embalmer No. *4461* .....

P. O. Address *Shelburne, Vt* .....

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.