

FEDERAL BUREAU OF INVESTIGATION
 FBI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-018720

FILED VS MAY 27 1960

Registration District No. 71 Primary Registration District No. 3012 Registrar's No. 55

STATE FILE NUMBER

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|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>CLAY</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>CLAY</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Excelsior Springs</u> | | Length of stay in lb <u>5 years</u> | c. CITY OR TOWN <u>Excelsior Springs</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>209 Cliff Drive</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>208 Cliff Drive</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First <u>Winnie</u> Middle <u>ADELIA</u> Last <u>Sparks</u> | | | 4. DATE OF DEATH Month <u>MAY</u> Day <u>18</u> Year <u>1960</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>white</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>2-1-1975</u> | 9. AGE (last birthday) <u>85</u> | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HR 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>Washington Kansas</u> | | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> |
| 13a. FATHER'S NAME <u>William G Wright</u> | | 13b. MOTHER'S MAIDEN NAME <u>Elizabeth Wilke</u> | | 14. NAME OF HUSBAND OR WIFE <u>Charles S. Sparks</u> | | |

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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | 16. SOCIAL SECURITY NO. <u>NONE</u> | 17. INFORMANT <u>MARGARET DeHoff Excelsior Springs, Mo.</u> |
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| 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>Acute Circulatory Failure.</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>second</u> <u>minute</u> <u>year</u> |
| Conditions, if any, which gave rise to above cause (e), stating the underlying cause last. | DUE TO (b) <u>Coronary Thrombosis</u> | |
| | DUE TO (c) <u>Chronic Arteriosclerosis</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |

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| 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 _____ a.m. _____ p.m. Month, Day, Year _____ | 20d. INJURY OCCURRED WHILE AT WORK <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 5-12-60 to 5-18-60 and last saw her alive on 5-15-60.
 Death occurred at 11:30 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE (Degree or title) <u>C. F. Lambert, D.O.</u> | | 22b. ADDRESS <u>121 G. Street Excelsior Springs Mo.</u> | | 22c. DATE SIGNED <u>5-18-60.</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u> | 23b. DATE <u>5- -60</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>McLouth Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>McLouth, Kansas</u> | |
| 24. FUNERAL DIRECTOR <u>Tyler Pasley Liberty, MO</u> | | 25. DATE RECD. BY LOCAL REG. <u>5-18-60</u> | 26. REGISTRAR'S SIGNATURE <u>Baroline Huettenberg</u> | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AUG 31 1960

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed John Pasley

Licensed Embalmer No. 4308

P. O. Address Liberty, 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.