

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-035213

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 1167

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED OCT 17 1963

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u>		Length of stay in 1b <u>10 years</u>	c. CITY OR TOWN <u>St. Joseph</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>509 E. Hyde Park Ave.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>509 E. Hyde Park Ave.</u>
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>D.</u> Last <u>Sparks</u>		4. DATE OF DEATH Month <u>October</u> Day <u>1</u> Year <u>1963</u>	
5. SEX <u>Male</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>Oct. 20, 1888</u>
9. AGE (last birthday) <u>74</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>Rev. Supt.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Swift & Co. Packing Co.</u>	11. BIRTHPLACE (City and state or country) <u>St. Joseph, Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>John Sparks</u>	
13b. MOTHER'S MAIDEN NAME <u>Susan DeVorss</u>		14. NAME OF HUSBAND OR WIFE <u>Hazel Sparks</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of serv.) <u>No</u>		17. INFORMANT Address <u>Mrs. Hazel Sparks 509 E. Hyde Park Ave.</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>Arteriosclerotic Heart Disease, decompensated</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Hypertensive Cardiovascular disease</u> PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown INTERVAL BETWEEN ONSET AND DEATH <u>Subarction in July 1961</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 _____ a.m. _____ p.m. Month, Day, Year _____		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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>7/25/59</u> to <u>10/1/63</u> and last saw him alive on <u>9/27/63</u> Death occurred at <u>died in sleep - found 8:00a</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Wm Redmond, M.D.</u> (Degree or title)		22b. ADDRESS <u>St. Joseph, Mo.</u>	
22c. DATE SIGNED <u>10/3/63</u> (State)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>Oct. 4, 1963</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Harrisburg Cemetery</u>		23d. LOCATION (City, town, or county) <u>Harrisburg, Penn.</u>	
24. FUNERAL DIRECTOR <u>Clark Funeral Home</u>		25. DATE RECD. BY LOCAL REG. <u>Oct. 4, 1963</u>	
26. REGISTRAR'S SIGNATURE <u>Mrs. Clark Goodell</u>			

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF
Wm Redmond, M.D.

VS 300
Rev: 4/59

1 5117

2 5117

3

4 0

5 1

6

7 0

8 2

9 4200

10

11

12 90-0

13 1-0

USE BLACK INK
OR
TYPEWRITER RIBBON

Dr. Redmond Corby Bldg.

2119
2119
0 - 0 4
0 22

Permit issued 10-1-63

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 Emm a Clark

Licensed Embalmer No. 4238

P. O. Address St. Joseph 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.