

**DISTRICT OF COLUMBIA DEPARTMENT OF PUBLIC HEALTH
CERTIFICATE OF DEATH**

Birth No.

File No.

69 5303

1. NAME OF DECEASED (Type or Print) <i>HARRY L. SPRATT</i>			2a. DATE OF DEATH Month <i>July</i> Day <i>3</i> Year <i>69</i>			2b. Hour of Death <i>10:30 PM</i>					
3. SEX <i>Male</i>	4. COLOR OR RACE <i>White</i>		5. MARRIAGE STATUS <i>MARRIED</i>	6. DATE OF BIRTH <i>July 10 87</i>		7. AGE (In years last birthday) <i>87</i>		8. If Under 1 Yr. Months Days		9. If Under 24 Hrs. Hours Min.	
8. PLACE OF DEATH IN <i>Washington, D.C.</i>				9. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)				10. a. STATE <i>DC</i> b. COUNTY			
NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (If not in institution, give street address) <i>Sheraton Park Hotel</i>				c. CITY <i>Washington</i>				e. INSIDE CITY LIMITS (SPECIFY YES OR NO)			
2660 Conn. Ave. N.W.				d. STREET ADDRESS (If rural, give location) <i>2660 Conn Ave N.W.</i>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Attorney</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>ATTORNEY</i>			11. BIRTHPLACE (State or foreign country) <i>VA</i>			12. CITIZEN OF WHAT COUNTRY? <i>US</i>		
13a. FATHER'S NAME <i>Wm SPRATT</i>			13b. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>			14. NAME OF SURVIVING SPOUSE <i>FAY D. SPRATT</i>					
15. Ever in U.S. Armed Forces?		16. SOCIAL SECURITY NO.		17. INFORMANT RELATIONSHIP TO DECEASED <i>Dillard SPRATT SON</i>		17a. ADDRESS Street City State <i>1200 So Convent St Alexandria VA</i>					
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) <i>Arteriosclerotic Cardiovascular Disease</i> (Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) DUE TO (b) <i>Ischemic</i> DUE TO (c) _____ PART II OTHER SIGNIFICANT CONDITIONS, contributing to death but not related to the terminal disease condition given in part I(a) _____ 19a. AUTOPSY? <i>NO</i> 19b. If Yes, Were Findings Considered in Determining Cause of Death? _____ IF OPERATION WAS PERFORMED COMPLETE ITEM 20a AND 20b. 20a. DATE OF OPERATION 20b. CONDITION FOR WHICH OPERATION WAS PERFORMED _____ 21a. Specify if accident, suicide, homicide, or manner undetermined 21b. HOUR AND DATE OF INJURY: Month, Day, Year <i>M</i> 21c. DESCRIBE HOW INJURY OCCURRED (Enter nature of Injury in Part I or Part II) _____ 21d. INJURY AT WORK (Specify Yes or No) 21e. PLACE OF INJURY: (At Home, Farm, Factory, Street or Office Building, Etc.) 21f. LOCATION CITY COUNTY STATE _____ 22. I certify that (1) (this hospital) attended the deceased from _____ to _____ that (2) (two) last saw the deceased alive on _____ and that death occurred between the causes and on the date and hour stated above. _____ 22a. SIGNATURE <i>Michael J. Willett</i> ATTENDING PHYS. <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <i>July 7, 1969</i> 22c. PHYSICIAN'S NAME (Type) _____ 22d. APPROVED BY _____ D. C. CORONER'S OFFICE											
24. FUNERAL HOME ADDRESS <i>Funeral Home of ...</i>				24a. UNDERTAKER'S SIGNATURE <i>...</i>				24b. UNDERTAKER'S REGISTRATION NUMBER <i>VEFC-146</i>			
REMARKS:											

Date Issued: **DEC 5 1979**

THIS IS TO CERTIFY THAT
OF THE ORIGINAL CERTIFI
DIVISION OF THE DEPARTM

NOT VALID WITHOUT RAISED SEAL

IS A TRUE AND CORRECT REPRODUCTION
IN ORDER WITH THE VITAL RECORDS
IN RESOURCES, DISTRICT OF COLUMBIA.

A. V. ...