MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

10458

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. .....

Township ..... Primary Registration District No. 1003 Registered No. 3053

City St Louis, Mo. (No. City Hosp. No 2 ..... St. ..... Ward)

2. FULL NAME Thomas Crook

(a) Residence. No. 2148 Beaumont St., 22 Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.
4. COLOR OR RACE: Negro.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Married.

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Not known

6. DATE OF BIRTH (MONTH, DAY AND YEAR): June 7, 1888.

7. AGE: Years 38 | Months 9 | Days 18 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Porter
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer: —

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY) Ga

PARENTS

10. NAME OF FATHER: Thomas Crook
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Ga
12. MAIDEN NAME OF MOTHER: Ellen Mitchell
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Ga

14. INFORMANT: Anna F. Woodard
(Address) City Hospital #2

15. FILED MAR 30 1927 May C Starkeoff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): March 25 1927

17. I HEREBY CERTIFY, That I attended deceased from March 24, 1927, to March 25, 1927, that I last saw him alive on March 25, 1927, and that death occurred, on the date stated above, at 10 30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar Pneumonia
108
(duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (SECONDARY) 101a
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? No. DATE OF .....
WAS THERE AN AUTOPSY? No.
WHAT TEST CONFIRMED DIAGNOSIS? Clinical & Laboratory
(Signed) J. W. Gray, M.D.
, 19 (Address) City Hosp. No 2

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Greenwood Cemetery
DATE OF BURIAL: 3/31. 1927

20. UNDERTAKER: Dunn Bros
ADDRESS: 215 S. Jefferson ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.