

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

Do not use this space.

15408

JUN 27 1927

**1. PLACE OF DEATH**

County Jackson

Registration District No. H00

Township Prairie

Primary Registration District No. 553B

City..... (No.....)

File No.....

Registered No. 69

St..... Ward)

**2. FULL NAME**

Thomas B. Crookes

(a) Residence, No. Leis Summit mo. Ward.....

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 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 White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mary A. Crookes

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 17 - 1852

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.  
75 4 12

8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work Retired  
(b) General nature of industry, business, or establishment in which employed (or employer) Matchman  
(c) Name of employer Turff Motor Co

9. BIRTHPLACE (CITY OR TOWN) Rockville  
(STATE OR COUNTRY) Indiana

10. NAME OF FATHER Not known

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....  
(STATE OR COUNTRY).....

12. MAIDEN NAME OF MOTHER.....

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....  
(STATE OR COUNTRY).....

14. INFORMANT O. E. Crookes  
(Address) Leis Summit mo.

15. FILE NO. 5/31 - 27 F. M. Schick  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 29 19 27

17. I HEREBY CERTIFY, That I attended deceased from April 26, 1927, to May 28, 1927  
that I last saw alive on May 27, 1927, and that death occurred, on the date stated above, at 2:10 p.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Carcinoma of bladder & prostate  
513  
516 (duration) 2 yrs. 6 mos. 0 ds.

CONTRIBUTORY (SECONDARY) None  
(duration)..... yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED Same  
IF NOT AT PLACE OF DEATH.....

1. DID AN OPERATION PRECEDE DEATH? yes DATE OF 4/19/25

WAS THERE AN AUTOPT? no

WHAT TEST CONFIRMED DIAGNOSIS Autopsy  
(Signed) F. Rappaport, M. D.  
, 19 (Address) Leis Summit Mo

\*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 Leis Summit Cem DATE OF BURIAL 5-31-1927

20. UNDERTAKER F. M. Schick ADDRESS Leis Summit Mo

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.

