

MAR 21 1928

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

Do not use this space.

## 1. PLACE OF DEATH

County St. Francois  
Township St. Francois  
City Near Farmington (No. ....)

Registration District No. 773  
Primary Registration District No. 6018A

File No. 6128  
Registered No. 74  
St. .... Ward)

2. FULL NAME John Rooks

(a) Residence. No. State Hospital No. 4 St. .... Ward. Crawford County, Mo.  
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 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) Widower

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Amanda Crabtree

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 29, 1854

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, .... hrs. or .... min.  
73 3 20

## 8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Laborer  
(b) General nature of industry, business, or establishment in which employed (or employer).....  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Crawford County  
(STATE OR COUNTRY) Missouri

10. NAME OF FATHER Wash Rook

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Not known  
(STATE OR COUNTRY) TENNESSEE

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Not known  
(STATE OR COUNTRY) Not known

14. INFORMANT Hospital Records  
(Address)

15. FILED 2-20-28 B. J. Robinson  
REGISTRAR

## 3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 19, 1928

17. HEREBY CERTIFY, That I attended Deceased from Feb 16, 1928 to Feb 19, 1928  
that I last saw him alive on Feb 19, 1928, and that death occurred, on the date stated above, at 11:20 P. m.

## THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Apoplexy  
22h  
97  
87 (duration) ..... yrs. .... mos. .... ds.  
CONTRIBUTORY arterio Sclerosis with  
(SECONDARY) mutal delirium (duration) ..... yrs. .... mos. .... ds.

## 18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?.....

D DID AN OPERATION PRECEDE DEATH? no DATE OF.....WAS THERE AN AUTOPSY? noWHAT TEST CONFIRMED DIAGNOSIS? Chemical(Signed) B. J. Robinson M. D., 19 (Address) Box #4 Farmington, 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 Cuba, Missouri, Kinder DATE OF BURIAL 2-21-1928

20. UNDERTAKER J. E. Hollow ADDRESS Cuba, 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.

