No. 2
1—2-43
5-17-39
I X35697

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DR. KNAOSS

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 42191

FILED DEC 28 1945

Registration District No. 2910 Primary Registration District No. 5984 Registrar's No.

1. PLACE OF DEATH:
(a) County PULASKI
(b) City or town RURAL Justice Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution LEBANON BROWNFIELD RT. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution —
In this community 25 YRS (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County PULASKI 85
(c) City or town LEBANON, BROWNFIELD RT. 0
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location) 0
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME ARCHIE C. ROOK
3. (b) If veteran, name war WORLD WAR ONE
3. (c) Social Security No. 486-24-0688
4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife LULA ALLEN
6. (c) Age of husband or wife if alive 38 years
7. Birth date of deceased OCT (Month) 27 (Day) 1889 (Year)

8. AGE: Years 56 Months — Days 27 If less than one day ____ hr. ____ min.

9. Birthplace PLATO (City, town, or county) MO (State or foreign country)
10. Usual occupation FARMER
11. Industry or business
FATHER 12. Name JOHN WM ROOK
13. Birthplace U.S. 1 (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name MARY YOUNG
15. Birthplace U S 1 (City, town, or county) (State or foreign country)
16. (a) Informant Mrs. A C Rook
(b) Address Lebanon Brownfield Rt.
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 11-27 45 (Month) (Day) (Year)
(c) Place: burial or cremation LEBANON MO
18. (a) Signature of funeral director PALMER'S
(b) Address LEBANON
19. (a) ____ (Date received local registrar) (b) ____ (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOV day 24 year 1945 hour 11 minute P.M.
21. I hereby certify that I attended the deceased from 8-4, 1945, to 11-24, 1945 that I last saw him alive on 11-24, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Angina pectoris	Duration
Due to —	
Due to —	
Other conditions — (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature Austin A. Knaoss (M. D. or other) D.O.
Address Lebanon, Mo. Date signed 12/3/45

(Licensed Embalmer's Statement on Reverse Side)

DEC 4 1947

DEC 29 1945

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed R. D. Palmer

Licensed Embalmer No. 1161

P. O. Address Lebanon 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 this body is not embalmed, fact should be so stated above.

S. No. 2B
M—3-45
I X43880

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. Primary Registration District No. Registrar's No.

1. PLACE OF DEATH:

(a) County: Pulaski

(b) City or town: Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME: Archie C. Rock

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex: M

5. Color or race: W

6. (a) Single, widowed, married, divorced: M

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive

7. Birth date of deceased: Oct 27 1888 (Month) (Day) (Year)

8. AGE: Years 56 Months Days If less than one day hr. min.

9. Birthplace (City, town, or county) MO (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) Feb 1-46 (Date received local registrar) (b) Chas M Cadd (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Day year 1945 hour minute M.

21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw him alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death — Duration

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY 2x

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