

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED JUN 27 1955

State File No. **20361**  
5225  
Registrar's No.

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>5225</b>	
1. PLACE OF DEATH a. COUNTY _____			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Illinois</b> b. COUNTY <b>Edwards</b>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST. LOUIS, MISSOURI</b>			c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <b>Grayville</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> <b>90</b>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>			e. STREET ADDRESS (If rural, give location) <b>8178</b>				
3. NAME OF DECEASED (Type or Print) a. (First) <b>MAE</b> b. (Middle) <b>(NMI)</b> c. (Last) <b>ROOKS</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>June 14, 1955</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Nov. 29, 1890</b>		9. AGE (In years last birthday) <b>64</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Clay County, Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Adam Schrader</b>			13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Joe Rooks</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Joe Rooks Grayville, Illinois.</b> ADDRESS _____			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Mesenteric Thrombosis</b>  ANTECEDENT CAUSES DUE TO (b) <b>Cardiovascular Disease</b> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 hrs.</b>  <b>yrs.</b>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____		21d. HOW DID INJURY OCCUR? <b>5702</b>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22. I hereby certify that I attended the deceased from <b>6-13-1955</b> , to <b>6-14-1955</b> , that I last saw the deceased alive on <b>6-14-1955</b> , and that death occurred at <b>8:35 P.m.</b> , from the causes and on the date stated above.			
23a. SIGNATURE <b>C. D. Miller M.D.</b> (Degree or title) <b>M. D.</b>			23b. ADDRESS <b>BARNES HOSPITAL</b>		23c. DATE SIGNED <b>6-15-55</b>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>6-15-55</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Local</b>		24d. LOCATION (City, town, or county) (State) <b>Grayville, Illinois.</b>		
DATE REC'D BY LOCAL REG. <b>JUN 16 1955</b>		REGISTRAR'S SIGNATURE <b>Carl Smith M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Albert H. Hoppe 4700 Washington.</b>			

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

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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....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Elmo R. Padwell*.....

Licensed Embalmer No. *40*.....

P. O. Address *St. Louis*.....

.. 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.