

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-020888  
STATE FILE NUMBER

FILED JUL 7 1958 Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 286

1. PLACE OF DEATH a. COUNTY <b>Boone</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> No. COUNTY <b>Callaway</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Columbia</b>		c. CITY OR TOWN <b>Williamsburg</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>UNIVERSITY MEDICAL Center</b>		d. STREET ADDRESS (If outside, give location) <b>Route 1</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>TURNER GRAY Hook</b>		4. DATE OF DEATH Month Day Year <b>June 30 1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/21/12</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>46</b>
11. BIRTHPLACE (City and state or country) <b>Williamsburg, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>William L. Hook</b>		13b. MOTHER'S MAIDEN NAME <b>MARtha BERAY</b>	14. NAME OF HUSBAND OR WIFE <b>Ruby Hook</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>-</b>	17. INFORMANT Address <b>Patients Hospital Record</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>arteriolar nephrosclerosis</b> DUE TO (c) <b>Essential Hypertension</b>			INTERVAL BETWEEN ONSET AND DEATH <b>446X</b>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from <b>June 24-28</b> to <b>June 30 1958</b> and last saw her/him alive on <b>June 30 1958</b> Death occurred at <b>3:20 PM</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>J. M. Mertz M.D.</b>		22b. ADDRESS <b>Columbia Mo</b>	22c. DATE SIGNED <b>6/30/58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>7/2/58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Riverview</b>	23d. LOCATION (City, town, or county) (State) <b>Steedman Missouri</b>
24. FUNERAL DIRECTOR ADDRESS <b>Margie F. N. Fulton Inc</b>		25. DATE RECD. BY LOCAL REG. <b>July 1, 1958</b>	26. REGISTRAR'S SIGNATURE <b>Mrs R E Palmer</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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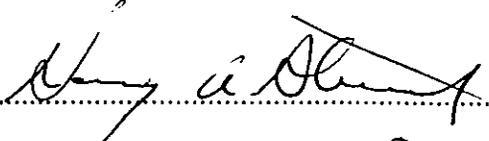
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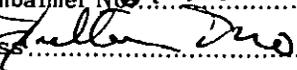
STATEMENT BY LICENSED EMBALMER

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  .....

Licensed Embalmer No. 3222

P. O. Address 

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.