

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-043106

STATE FILE NUMBER

*Crain*  
FILED NOV 25 1958

Registration District No. 378 Primary Registration District No. 4552 Registrar's No. 45

300  
1-57

1. PLACE OF DEATH a. COUNTY <u>Wright</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Wright</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Mountain Grove</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Mountain Grove</u> <u>1141</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>518 West First St.</u>		Length of stay in 1b <u>life</u>	d. STREET ADDRESS (If outside, give location) <u>518 West First Street</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Guy</u> Middle <u>Rook</u> Last <u>Rook</u>			4. DATE OF DEATH Month <u>November</u> Day <u>12</u> Year <u>1958</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 21, 1895</u>
9. AGE (In years last birthday) <u>63</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Horticulturist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fruit trees</u>	11. BIRTHPLACE (City and state or country) <u>Plato, Missouri</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>William Rook</u>	
13b. MOTHER'S MAIDEN NAME <u>Eva Combs</u>		14. NAME OF HUSBAND OR WIFE <u>Mrs Jenia Crewse Rook</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>350X</u>	
17. INFORMANT <u>Mrs Jenia Rook</u>		Address <u>Mountain Grove, Missouri</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Parkinson's Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>17 years</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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.) <u>350X</u>	
20c. TIME OF INJURY Hour _____ .Month, Day, Year _____ a.m. _____ p.m. _____			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT 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 <u>June 1948</u> to <u>11-11-58</u> and last saw <sup>her</sup> him alive on <u>11-11-58</u> Death occurred at <u>5:30 A.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>W. A. Crain</u> (Degree or title) <u>D.O. 2</u>		22b. ADDRESS <u>Mountain Grove Mo</u>	22c. DATE SIGNED <u>11-18-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11/15/1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cemetery</u>	23d. LOCATION (City, town, or country) (State) <u>Mountain Grove, Missouri</u>
24. FUNERAL DIRECTOR <u>Barber Funeral Home</u> ADDRESS <u>Mtn. Grove, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>11-20-1958</u>	26. REGISTRAR'S SIGNATURE <u>Bernice R. Silverman</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

