

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 18 1959

59-030325

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **8 7307**

9/9/59  
 DOCUMENT Ser. Serv. statement 3/24/1937  
 59  
 MEDICAL CERTIFICATION  
 57  
 9  
 BY AFFIDAVIT OF Informant

|   |   |   |   |  |   |   |  |   |
|---|---|---|---|--|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>St. Louis</b>   |   |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> COUNTY _____ |   |   |  |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>ST. LOUIS, MO.</b>  |   | Length of stay in 1b _____  |   | c. CITY OR TOWN <b>St. Louis</b>   |   | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |  |   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSP. #1.</b>  |   |   | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location)<br><b>5443 N. Euclid Ave</b>   |   |   | Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>JERRY</b> Middle <b>M</b> Last <b>CROOK</b>   |   |   |   | 4. DATE OF DEATH<br>Month <b>AUG.</b> Day <b>4,</b> Year <b>1959</b>   |   |   |  |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b>  | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><del>4-6-1900</del> <b>59</b><br><b>April 6, 1902</b>  | 9. AGE (last birthday)<br><b>57</b>                                     | IF UNDER 1 YEAR<br>Months _____ Days _____ Hours _____ Min. _____         | IF UNDER 24 HR<br>Hours _____ Min. _____                                   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during last 12 months, even if retired)<br><b>Mechanists</b>  |   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Crocker Texas</b>                 |  | 11. BIRTHPLACE (City and state or country)<br><b>Texas</b>              |   |  | 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b> |
| 13a. FATHER'S NAME<br><b>Jeremiah Cook</b>  |   |   | 13b. MOTHER'S MAIDEN NAME<br><b>Narissa</b>                               |  |   | 14. NAME OF HUSBAND OR WIFE<br><b>Myrtle</b>                              |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>yes US Army</b>  |   | 16. SOCIAL SECURITY NO.<br><b>498-05-6447</b>   |   | 17. INFORMANT Address<br><b>Myrtle Crook 5443 N. Euclid Ave</b>  |   |   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>aspiration pneumonia 199.2</b><br>DUE TO (b) <b>generalized carcinoma - of</b><br><del>DUE TO (c)</del> <b>pancreas, adrenal, lung, stomach</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____<br>PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |   |   |   |  |   |   |  |   |
| 19. WAS AUTOPSY PERFORMED?<br>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.) _____  |   |  |   |   |  |   |
| 20c. TIME OF INJURY<br>Hour _____ a.m. _____ p.m. _____   |   | 20d. INJURY OCCURRED WHILE AT WORK <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<br><b>7/20/59</b> to <b>8/4/59</b>   |   | 20g. COUNTY<br><b>St. Louis</b>  |   | 20h. STATE<br><b>Mo</b>   |  |   |
| 21. I attended the deceased from <b>7/20/59</b> <b>9:05 A.M.</b> to <b>8/4/59</b> and last saw her/him alive on <b>8/4/59</b> .<br>Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.   |   |   |   |  |   |   |  |   |
| 22a. SIGNATURE (Degree or title)<br><b>Robert L. Maloney, M.D.</b>  |   |   |   | 22b. ADDRESS<br><b>1515 LAFAYETTE AVE</b>  |   | 22c. DATE SIGNED<br><b>8/4/59</b>   |  |   |
| 23a. BURIAL, CREMATION, etc. (Specify)<br><b>Burial</b>   | 23b. DATE<br><b>Aug. 7-1959</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Memorial Park Cemetery</b>   |   | 23d. LOCATION (City, town, or county) (State)<br><b>St. Louis Mo</b>   |   |   |  |   |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Sullivan Funeral 1150 N. Kingshighway</b>  |   |   | 25. DATE RECD. BY LOCAL REG.<br><b>AUG 6 '59</b>                          |  | 26. REGISTRAR'S SIGNATURE<br><b>Carl Smith, M.D.</b><br><i>M. G. B.</i> |   |  |   |

**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 Harvey Keeble

Licensed Embalmer No. 4596

P. O. Address St Louis, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.