

MARGIN RESERVED FOR BINDING
 WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County White
 Civil Dist. 9
 OR
 Village Cookeville
 OR
 City (No. _____ St.; _____ Ward)

STATE OF TENNESSEE

STATE BOARD OF HEALTH
 Bureau of Vital Statistics
 CERTIFICATE OF DEATH 28273

Registration District No. 944
 Primary Registration District No. _____

File No. _____
 Registered No. 12

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Gabrie Brown Crook

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male
 4 COLOR OR RACE White
 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) widowed
 6 DATE OF BIRTH May 22 1931
 (Month) (Day) (Year)

7 AGE 95 yrs. 5 mos. 19 ds.
 If LESS than 1 day, _____ hrs. or _____ min.?

8 OCCUPATION
 (a) Trade, profession, or particular kind of work Oil Farm
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Tennessee

10 NAME OF FATHER John Crook

11 BIRTHPLACE OF FATHER [State or country] Tennessee

12 MAIDEN NAME OF MOTHER Sallie Brown

13 BIRTHPLACE OF MOTHER [State or country] Tennessee

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 [Informant] Gland Crook
 [Address] Cookeville Tenn

15 Filed Nov 24 1926 A. A. Bradley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 11 1926
 [Month] [Day] [Year]

17 I HEREBY CERTIFY, That I attended deceased from _____ 191____ to _____ 191____, that I last saw him _____ alive on _____ 191____ and that death occurred, on the date stated above, at 6 a.m.
 The CAUSE OF DEATH* was as follows:

Died sudden
no doctor all age
 [Duration] _____ yrs. _____ mos. _____ ds.

Contributory [SECONDARY] _____
 [Duration] _____ yrs. _____ mos. _____ ds.

Signed _____ M. D.
 _____ 191____ Address _____

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS TRANSIENTS, OR RECENT RESIDENTS]
 At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.
 Where was disease contracted, if not at place of death?
 Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Zion Cemetery DATE OF BURIAL 11/17 26
 20 UNDERTAKER H. B. Hunter ADDRESS Sparta Tenn