

**NORTH CAROLINA STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS**

3 S DEC 6 1944

CERTIFICATE OF DEATH

22958

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
Every item of information should be carefully supplied. The correct age is especially important.
Please write the causes of death clearly and legibly.

I. PLACE OF DEATH:			
(a) County	Halifax		
(b) Township	(If in town limits, leave blank)		
(c) City or town	Roanoke Rapids		
(If outside city or town limits, write RURAL)			
(d) Street, hospital or institution	R.R.Hosp.		
(e) Length of stay in hospital or institution	15 Hours		
(Yrs., mos., or days)			
In this community _____			
(Yrs., mos., or days)			
3(a) FULL NAME	Wade A. Cook		
3(b) If veteran, name war	3(c) Social Security No.		
4. Sex Male	5. Color or Race White	6(a) Single, married, widowed or divorced. Married	
6(b) Name of husband or wife Annie Bell Cook	62	years	
(e) Age of husband or wife if alive			
7. Birth date of deceased	Oct. 20 1884		
(month, day and year)			
8. AGE: 61	Years	Months	Days
			If less than one day hrs. ____ min.
9. Birthplace Northampton Co.	(City, town, or county) (State or foreign country)		
10. Usual occupation Farmer			
11. Industry or business			
12. Name Salmon Cook			
13. Birthplace Northampton Co.			
14. Maiden Name Rose Garner			
15. Birthplace Northampton Co.			
16(a) Informant's Signature Mrs Wade A. Cook			
(b) Address Garysburg N.C. R.R. Box 83			
17(a) Burial (Burial, cremation, or removal)	(b) Date thereof 11-12-45 (Month, day, year)		
(c) Cemetery Leboan Church			
(d) Location Northampton Co.			
18(a) Funeral director J. R. Menn			
(b) Address Roanoke Rapids N.C.			
19(a) 11-27-45	(b) E. K. [Signature]		
Filed			

Registration Dist. No.	42-60	Certificate No.	135
2. HOME (USUAL RESIDENCE) OF DECEASED:			
(a) State	N.C.	(b) County	Nor thamptor
(c) City or town	Garysburg		
(d) Street or R.F.D.	R.1 Box 83		
(e) Is place of residence in corporate limits?	No.		
(f) If foreign born, how long in U.S.A.?		years.	
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MEDICAL CERTIFICATION			
20. Date of death	NOV. 11	19 45	at _____ M
21. I certify that death occurred on the date above stated; that I attended deceased from NOV - 10 1945 to NOV - 11 1945 and that I last saw him alive on NOV - 11 1945			
immediate cause of death	Duration		
Pistol Wound in Brain	11 hrs.		
due to			
due to			
Other conditions	Physician		
(Include pregnancy within 3 months of death)			
Major findings:	Underline the cause to which death should be charged statistically.		
Of operations			
Of autopsy			
If death was due to external causes, fill in the following:			
Accident, suicide, or homicide (specify)	Homicide		
Date of occurrence			
Where did injury occur?			
Did injury occur about home, on farm, in industrial place, in a public place?	(City or town)	(County)	(State)
While at work	(Specify type of place)		
Means of injury	+ Madely		
Signature	M.D.		
Address	Locality Rapids Date signed 11-26-45		