

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

12214

1. PLACE OF DEATH

County Dunklin
Township
City Malden (No.)

Registration District No. 289
Primary Registration District No. 4173

File No.
Registered No. 13
St. Ward)

2. FULL NAME Krona Emma Looney

(a) Residence. No. St. Ward.

(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Widow</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED <u>HUSBAND OR</u> (OR) WIFE OF <u>Tom Looney</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Nov. 2-1868</u>		
7. AGE	YEARS <u>61</u>	MONTHS <u>5</u>
	DAYS <u>3</u>	IF LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>at home</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>retired</u> (c) Name of employer <u>none</u>		

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Conway Co. Ark.

PARENTS	10. NAME OF FATHER <u>John G. Rorie</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Tenn.</u>
	12. MAIDEN NAME OF MOTHER <u>Nancy Crylle</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Mo.</u>

14. INFORMANT Tom J. Looney
(Address) Augusta Ark.

15. FILED 4/5/30 S.E. Mitchell
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2
16. DATE OF DEATH (MONTH, DAY AND YEAR) April 5 1930

17. I HEREBY CERTIFY, That I attended deceased from March 26, 1930, to April 5, 1930 that I last saw h. e. alive on April 4, 1930, and that death occurred, on the date stated above, at 2:45 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Tetanus
22
69B
(duration) yrs. mos. 9 ds.
CONTRIBUTORY (SECONDARY) Acidosis
(duration) yrs. mos. 4 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH.....
0 DID AN OPERATION PRECEDE DEATH? No DATE OF.....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical Findings
(Signed) John Van Clave M. D.
4-5 1930 (Address) Malden Mo

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL <u>Malden Mo.</u>	DATE OF BURIAL <u>4-6 1930</u>
20. UNDERTAKER <u>H. L. Craig</u>	ADDRESS <u>Malden</u>

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

20

35
88
23
1930

