

REC'D JUL 17 1938

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

22220

1. PLACE OF DEATH

County Johnson
Township Washington
City Waynesville (No. _____) (St. _____ Ward)

Registration District No. 429
Primary Registration District No. 0-5-9-18

File No. 14
Registered No. _____

2. FULL NAME Anna Lee Looney

1011

(a) Residence No. 51 (Usual place of abode) St. _____ Ward _____

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE black 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 17 - 1919

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
18 9 16

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Oceola (STATE OR COUNTRY) Mo

10. NAME OF FATHER Clint Looney

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Conium (STATE OR COUNTRY) Mo

12. MAIDEN NAME OF MOTHER Rosie Cooper

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Oceola (STATE OR COUNTRY) Mo

14. INFORMANT (Address) Mrs Elizabeth Cooper
1208 N. 1st St. Mo.

15. FILED July 3 19 1938 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

15. DATE OF DEATH (MONTH, DAY AND YEAR) June 2, 1938

17. I HEREBY CERTIFY, That I attended deceased from March 1, 1938 to June 2, 1938 that I last saw her alive on June 2, 1938 and that death occurred, on the date stated above, at 10:20 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary tuberculosis
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) ✓ 23h
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Physical

(Signed) W. J. Snow M. D.

, 19 (Address) 1208 N. 1st St. 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 Oceola Mo DATE OF BURIAL June 3 1938

20. UNDERTAKER E. L. Sault ADDRESS K. N. Mo.

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

1. PLACE OF DEATH

County..... Registration District No.....
 Township..... Primary Registration District No.....
 City..... (No..... St..... Ward)

File No.....
 Registered No.....

2. FULL NAME.....

(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. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day,hrs. ormin.
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8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work.....
 (b) General nature of industry, business, or establishment in which employed (or employer).....
 (c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN).....
 (STATE OR COUNTRY)

PARENTS	10. NAME OF FATHER
	11. BIRTHPLACE OF FATHER (CITY OR TOWN)..... (STATE OR COUNTRY)
	12. MAIDEN NAME OF MOTHER
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN)..... (STATE OR COUNTRY)

14. INFORMANT.....
 (Address)

15. FILED..... 19..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 2 19

17. I HEREBY CERTIFY, That I attended deceased from....., 19....., to....., 19..... (that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

..... (duration) yrs..... mos..... ds.

CONTRIBUTORY (SECONDARY)..... (duration) yrs..... mos..... ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH.....
 DID AN OPERATION PRECEDE DEATH?..... DATE OF.....
 WAS THERE AN AUTOPSY?.....
 WHAT TEST CONFIRMED DIAGNOSIS?.....
 (Signed)....., M. D.
 , 19 (Address)

*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	DATE OF BURIAL
	19

20. UNDERTAKER	ADDRESS
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