

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.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

SEP 12 1939

Registration District No. 318

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 2001

State File No. 29164

Registrar's No. 647

1. PLACE OF DEATH:

- (a) County Greene
- (b) City or town Springfield
- (c) Name of hospital or institution: St. James Hospital  
(If not in hospital or institution, write street number or location)
- (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether years, months or days)

In this community \_\_\_\_\_

- 3. (a) PRINT FULL NAME Infant  
Waldo R. Looney 509
- 3. (b) If veteran, name war \_\_\_\_\_
- 3. (c) Social Security No. \_\_\_\_\_

- 4. Sex Male
- 5. Color or race White
- 6. (a) Single, widowed, married, divorced \_\_\_\_\_
- 6. (b) Name of husband or wife \_\_\_\_\_
- 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Aug. 21 - 1939  
(Month) (Day) (Year)

8. AGE: Years 0 Months 0 Days 0 If less than one day hr. 0 min. 0

9. Birthplace Springfield Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

- 12. Name Waldo R. Looney
- 13. Birthplace Mo.  
(City, town, or county) (State or foreign country)
- 14. Maiden name Grace Cripps
- 15. Birthplace Mo.  
(City, town, or county) (State or foreign country)

- 16. (a) Informant's signature Waldo R. Looney
- (b) Address 73 E. S. Mo. Ave
- 17. (a) Burial (b) Date thereof Aug 21 1939  
(Burial, cremation, or removal) (Month) (Day) (Year)
- (c) Place: burial or cremation East Lawn Cemetery
- 18. (a) Signature of funeral director Joseph A. George
- (b) Address Springfield Mo.
- 19. (a) 8-21-1939 (b) Chas. A. George  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State \_\_\_\_\_ (b) County \_\_\_\_\_
- (c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")
- (d) Street No. \_\_\_\_\_  
(If rural, give location)
- (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

- 20. DATE OF DEATH: Month Aug day 21 year 1939 hour 4 minute 00 A. M.
- 21. I hereby certify that I attended the deceased from Aug 21 1939 to Aug 21 1939; that I last saw him dead also on Aug 21 1939; and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity (5 mo's baby)  
Due to miscarriage

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

- 22. If death was due to external causes, fill in the following:
  - (a) Accident, suicide, or homicide (specify) \_\_\_\_\_
  - (b) Date of occurrence \_\_\_\_\_
  - (c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)
  - (d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_  
23. Signature Joseph A. George (M. D. or other) \_\_\_\_\_  
Address Springfield Mo. Date signed 8/21/39

---

---

**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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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 this body is not embalmed, above space should be left blank.**