

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

32012  
 Do not use this space.

OCT 12 1939

1. PLACE OF DEATH

(a) County Ballouay Registration District No. 104

(b) Township 1 Primary Registration District No. 3008

(c) City Jackson (d) Street No. State Hospital No 1 Registered No. 243

(If death occurred in Hospital or Institution, write its name instead of street and number)

(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Jennie M. Louney

(a) Residence, No. Vandalia Mo. St.  (If nonresident, give city or town and State)

(Usual place of abode, if no street address, write county or city)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF married P.A. Louney

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 15K

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>69</u>	<u>2</u>	<u>2</u>	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) mo

FATHER

13. NAME B.K.

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) B.K. Unknown

MOTHER

15. MAIDEN NAME Unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (ADDRESS) P.A. Louney Vandalia mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Vandalia Mo DATE Sept 5 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) R. D. Hale Vandalia mo

20. FILED Sept 4 1939 R. N. Crews Local Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 9 1939

22. I HEREBY CERTIFY, That I attended deceased from Aug 30 1939, to Sept 3 1939

I last saw her alive on Sept 3 1939. Death is said to have occurred on the date stated above, at 5:16 a.m.

The principal cause of death and related causes of importance were as follows:

Chronic Myocarditis

Date of onset

Other contributory causes of importance:

Epileptic Recurrence (Cause unknown) Hypertension + arterio sclerosis

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? Chol. Test Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_ (Signed) James Thomas M. D.

(Address) State Hospital No 1

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.

**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.....

*W B Waters*

Licensed Embalmer No.....

*3625*

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.**