

FILED OCT 9 1942
Registration District No. **171**

Primary Registration District No. **5637**

Registrar's No. **53**

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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Lafayette
(b) City or town Rural - Clay
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
7 mi. North West Odessa Mo.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 42 yrs 8 mo 25 da. years, months or days

3. (a) PRINT FULL NAME Mary Pauline Looney

3. (b) If veteran, name war none 3. (c) Social Security No. none

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Cliff Looney 6. (c) Age of husband or wife if alive 44 years
7. Birth date of deceased Dec 23 1899 (Month) (Day) (Year)

8. AGE: Years 42 Months 8 Days 25 If less than one day _____ hr. _____ min.

9. Birthplace Near Odessa Mo. A (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name A. S. Maffray
13. Birthplace Near Napoleon Mo. A (City, town, or county) (State or foreign country)
14. Maiden name Estelle Thomas
15. Birthplace Near Napoleon Mo. A (City, town, or county) (State or foreign country)

16. (a) Informant Cliff Looney
(b) Address Odessa Mo.

17. (a) Burial (b) Date thereof 9-20-1942 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pleasant Prairie

18. (a) Signature of funeral director Blanca Lane

(b) Address Odessa Mo.

19. (a) Sept 19-1942 (b) Mr W.F. Baker (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lafayette
(c) City or town Rural - 7 mi. N.W. Odessa A
(If outside city or town limits, write "RURAL")
(d) Street No. 7 mi. N.W. Odessa
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 18 year 1942 hour 1 minute 15 A. M.

21. I hereby certify that I attended the deceased from 1935 to Sept. 18, 1942, that I last saw her alive on Sept. 18, 1942, and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia of the small lung branch Duration 6 hrs.

Due to Progressive muscular atrophy 2 yrs

Due to _____
Other conditions none (Include pregnancy within 3 months of death)

PHYSICIAN _____
Major findings: Of operations none
Of autopsy none
Underline the cause so which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) no
(b) Date of occurrence 0
(c) Where did injury occur? 0 (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? 0
While at work? 0 (Specify type of place) (e) Means of injury 0

23. Signature [Signature] (M. D. State) _____
Address Odessa Mo. Date signed 9/19/42

OCT 16 1942

District Health Officer No. 8,

District File Number _____

Date Filed 10-8-42

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 Grace Plunkett

Licensed Embalmer No. 2758

P. O. Address Chicago, Ill.

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 30695
Registrar's No. 53

Registration District No. 171 Primary Registration District No. 5637

1. PLACE OF DEATH:

(a) County Lafayette
(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME Mary Pauline Looney

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Dec 23
(Month) (Day) (Year)

8. AGE: Years 42 Months 8 Days 10 If less than one day _____ min. no

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____ (City, town, or county) (State or foreign country)

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ year 1942 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____;
that I or saw him _____ alive on _____ 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death Paralysis of the small intestine Duration 6 hrs

Due to Progressive muscular atrophy 2 yrs.
Due to Paralysis of the small intestine

Other conditions atrophy The paralysis of the hand started after _____
(Include pregnancy within 3 months of death)

Major findings: The muscular atrophy reached the drop stage
Of operations _____
Of autopsy _____

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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 [Signature] (M. D. or other) _____

Address [Address] Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

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