

FILED FEB 10 1944

Registration District No. **553**

Primary Registration District No. **3010**

Registrar's No. **28**

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

1. PLACE OF DEATH: *Cape Girardeau*
 (a) County *Cape Girardeau*
 (b) City or town *Cape Girardeau*
 (c) Name of hospital or institution: *Southeast MO Hospital*
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution *4 days* (Specify whether
 In this community *4 days*
 years, months or days)

3. (a) PRINT FULL NAME **B. FRANKLIN LOONEY**
 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, *married*

6. (b) Name of husband or wife *Jane Cole Looney* 6. (c) Age of husband or wife if alive *82 1/2* years

7. Birth date of deceased *Dec 13 - 1860*
 (Month) (Day) (Year)

8. AGE: Years *83* Months *1* Days *4* If less than one day hr. min.

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

10. Usual occupation *Farmer*

11. Industry or business

12. Name *B. F. Looney*

13. Birthplace *1 Res. 1*
 (City, town, or county) (State or foreign country)

14. Maiden name *Catherine Lingenbrunner*

15. Birthplace *Stroder Community, Cape Gir. Co. Mo.*
 (City, town, or county) (State or foreign country)

16. (a) Informant *Walter L. Miller*

(b) Address *Cape Girardeau Mo*

17. (a) *Burial* (b) Date thereof *1-19-44*
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation *Looney Cemetery*

18. (a) Signature of funeral director *Jackson Mo*

(b) Address *Jackson Mo*

19. (a) *1-20-44* (b) *F. W. Jackson*
 (Date received local registrar) (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State *MO* (b) County *Cape Girardeau*
 (c) City or town *Cape Girardeau*
 (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.? *NO* years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Jan* day *17*
 year *1944* hour *5* minute *30 AM*

21. I hereby certify that I attended the deceased from *1-12-44* to *1-17-44*
 that I last saw him alive on *1-17-44*
 and that death occurred on the date and hour stated above.

Immediate cause of death: *Left Cerebral Apoplexy*

Due to *1. Unknown Arteriosclerosis*
2. Hypertension

Due to *2. Debility*

Other conditions (include pregnancy within 3 months of death) *JZ*

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 *Alfred L. Jackson* (M. D. or other) *Phys*
 Address *Jackson Mo* Date signed *1-17-44*

Duration
 Underline the cause to which death should be charged statistically.

RECEIVED

FEB 10 1944

District Health Officer No. _____
District File Number 244-3402
Date Filed 2-9-44

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 J. E. Graham

Licensed Embalmer No. 4017

P. O. Address: Luterville, Mo.

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, fact should be so stated above.