

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 159 PRIMARY REG. DIST. NO. 4249 Registrar's No. 37

1. PLACE OF DEATH a. COUNTY <u>Jefferson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Jefferson</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Hillsboro</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Home Springs</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Cedar Grove Nursing Home Hillsboro</u>		d. STREET ADDRESS (If rural, give location) <u>Warrens Township</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>JAMES</u> b. (Middle) <u>M.</u> c. (Last) <u>LOONEY</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>18</u> (Year) <u>1951</u>	
5. SEX <u>MO</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>W</u>	8. DATE OF BIRTH <u>Jan 26-1855</u>
9. AGE (In years last birthday) <u>96</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cooper</u>	11. BIRTHPLACE (State or foreign country) <u>Mo</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>James Looney</u>		13b. MOTHER'S MAIDEN NAME <u>Mary</u>	
13c. NAME OF HUSBAND OR WIFE <u>Mary Jane Hubbs</u>		14. NAME OF HUSBAND OR WIFE <u>Mary Jane Hubbs</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Flossie M. Cugnet</u>		ADDRESS <u>Home Springs</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Cardio-Vascular</u>  ANTECEDENT CAUSES <u>① Mitral regurgitation</u> <u>② arterio-sclerosis</u> DUE TO (b) _____ DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<u>4221</u>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21d. HOW DID INJURY OCCUR?	
21e. TIME OF INJURY (Month) (Day) (Year) (Hour)		21f. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>21 Feb</u> , 19 <u>51</u> , to <u>18 May</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>17 May</u> , 19 <u>51</u> , and that death occurred at _____ m., from the causes and on the date stated above.			
23a. SIGNATURE <u>William Howard</u>		23b. ADDRESS <u>Home Springs Mo</u>	
23c. DATE SIGNED <u>18 May 51</u>		23d. SIGNATURE <u>William Howard</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>5/19/51</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>Lakewood Park Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis Mo</u>	
DATE REC'D BY LOCAL REG. <u>5-23-51</u>		REGISTRAR'S SIGNATURE <u>Kathleen Maradone</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Smith</u>		ADDRESS <u>Home Springs Mo</u>	

15500  
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

23

JEFFERSON COUNTY HEALTH DEPT.  
HILLSBORO, MISSOURI

DATE RECEIVED 5-31-57  
M.H.H.  
7  
C. H. H.

**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed \_\_\_\_\_

*John H. Brimmer*

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. \_\_\_\_\_

1470

P. O. Address \_\_\_\_\_

Home Springs 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.