

Health,
Welfare
Public
Service

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED OCT 5 1956

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

Registration District No. 709 Primary Registration District No. 3043 Registrar's No. 330

1. PLACE OF DEATH a. COUNTY <u>Marion</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Audrain</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Hannibal</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Vandalia</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Elizabeth's Hospital</u>			Length of stay in 1b <u>18 days</u>		d. STREET ADDRESS (If outside, give location) <u>112 W. State St.</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Patrick</u> Middle <u>Aloysius</u> Last <u>Louney</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>14</u> Year <u>1956</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 19, 1874</u>		9. AGE (In years last birthday) <u>82</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, open if retired) <u>Ret. Foreman (brick)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Harbison-Walker Refr. Co.</u>		11. BIRTHPLACE (City and state or country) <u>Mill Hall, Pa. R.F.D.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>John A. Louney</u>				14. MOTHER'S MAIDEN NAME <u>Anne (unknown)</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>497-07-1007</u>		17. INFORMANT <u>Eleanor Hartung</u> Address <u>Vandalia, Mo. 506 E. Highway 54</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage Rt c lgt</u> <u>hemiplegia</u> <u>granuloma arteriosclerotic</u> <u>cardiac hypertensive</u>								INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>5 days</u> <u>4 years</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b)		DUE TO (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>331.X</u>									
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour <u>5:00</u> Month <u>Sept</u> Day <u>14</u> Year <u>1956</u> a. m. <u>AM</u> p. m.									
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION <u>Vandalia</u>		COUNTY <u>Audrain</u>		STATE <u>Missouri</u>	
21. I attended the deceased from <u>June 1952</u> to <u>Sept 14, 56</u> and last saw <u>him</u> alive on <u>Sept 14, 56</u> . Death occurred at <u>5 AM</u> on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>Frank M. M.</u> (Degree or title)				22b. ADDRESS <u>Vandalia Mo</u>		22c. DATE SIGNED <u>9/25/56</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>1956</u> <u>Sept. 17,</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Vandalia, Mo. Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Vandalia Missouri</u>			
24. FUNERAL DIRECTOR <u>W. L. ...</u> ADDRESS <u>16 E. State</u>				25. DATE RECD. BY LOCAL REG. <u>9-27-56</u>		26. REGISTRAR'S SIGNATURE <u>Dr. Em. Lucke, Jr., W. P. Fisher</u>			

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED OCT 3 1956
MARION CO. HEALTH DEPT.
DATE FILED OCT 3 1956

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..

Student.....
Signature of Student Embalmer

Signed *William B. Mat...*

Licensed Embalmer No. *410*

P. O. Address *Vandalia*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.