

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 4576

FILED FEB 23 1950

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 5467 Registrar's No. 121

1. PLACE OF DEATH a. COUNTY <u>GREENE</u>		2. USUAL RESIDENCE (Where deceased lived - If institution, give name and address before death) a. STATE <u>MISSOURI</u> b. COUNTY <u>GREENE</u>	
b. CITY (If outside corporate limits, give RURAL and give township) <u>ROBERSON RURAL</u>		c. CITY OR TOWN <u>ROBERSON TWP.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>BRIGHTON R.F.D. #1</u>		d. STREET ADDRESS (If rural, give location) <u>BRIGHTON RFD #1 0</u>	

3. NAME OF DECEASED (Type or Print) <u>JESSE ALLEN LOY</u>	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) <u>FEB. 10 1950</u>
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5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>7 MARCH 1881</u>	9. AGE (In years last birthday) <u>69</u>	IF UNDER 1 YEAR Months	IF UNDER 12 HRS. Days	IF UNDER 1 MIN. Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED LABORER</u>	11. BIRTHPLACE (State or foreign country) <u>KANSAS</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>WALTER LOY</u>	13b. MOTHER'S MAIDEN NAME <u>ELLA ROGERS</u>	14. NAME OF HUSBAND OR WIFE <u>JENNIE LOY</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>4-10-1899 = 5-2-1902</u>	17. INFORMANT'S SIGNATURE OR NAME <u>JENNIE LOY</u>	ADDRESS <u>BRIGHTON, MO.</u>
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Lung Hemorrhage.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 mins.</u>	
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Carcinoma of Lung (Secondary)</u>			<u>10 mos.</u>
	DUE TO (c) <u>Carcinoma of Bowel (Primary)</u>			<u>3 yrs.</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>NONE.</u>		<u>152X</u>		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from June 13, 1949, to Feb 10, 1950, that I last saw the deceased alive on Feb. 4, 1950, and that death occurred at 3:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Harold R. Agnew D.O.</u>	23b. ADDRESS <u>Pleasant Hope, Mo.</u>	23c. DATE SIGNED <u>Feb 11, 1950</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>2-15-50</u>	24c. NAME OF CEMETERY OR CREMATORY <u>NATIONAL CEMETERY</u>	24d. LOCATION (City, town, or county) (State) <u>SPRINGFIELD MO.</u>
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DATE REC'D BY LOCAL REG. <u>5-13-50</u>	REGISTRAR'S SIGNATURE <u>H. Handley W.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Jew. Klingner &amp; Co.</u>	ADDRESS <u>Spfld. Mo.</u>
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WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

No. 300  
10.48  
390

1951

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

working under my personal supervision.

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

Signed \_\_\_\_\_

*Max Rhodes*

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

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

4071

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

*Springfield*

**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.