

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

37496  
State File No.

FILED DEC 1 1955

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 209 PRIMARY REG. DIST. NO. 30413 Registrar's No. 362

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>Marion</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Hannibal</u>		c. LENGTH OF STAY (in this place) <u>                    </u>	c. CITY OR TOWN <u>Hannibal</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Clarks Rest Home, 1125 Lyon</u>		e. STREET ADDRESS (If rural, give location) <u>2707 Hope Street</u>	

3. NAME OF DECEASED (Type or Print) <u>Lillia Stone Loy</u>	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) <u>November 28, 1955</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>December 8, 1863</u>	9. AGE (in years last birthday) <u>91</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>19</u>	IF UNDER 24 HRS. Hours <u>          </u> Min. <u>          </u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>                    </u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Pike County Illinois</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Reverend Jone O. Stone</u>	13b. MOTHER'S MAIDEN NAME <u>Elizabeth Mary Lacy</u>	14. NAME OF HUSBAND OR WIFE <u>LaPorte J. Loy (deceased)</u>
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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. Verna McKay Hannibal</u>	ADDRESS <u>Hannibal</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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Malnutrition</u>		10 months
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Carcinoma of Esophagus</u> DUE TO (c) <u>150X</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION <u>                    </u>	19b. MAJOR FINDINGS OF OPERATION <u>                    </u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>                    </u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>                    </u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>                    </u>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>                    </u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>                    </u>
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22. I hereby certify that I attended the deceased from 3-28-46, 19          , to 11-28-55, 19          , that I last saw the deceased alive on 11-28-55, 19          , and that death occurred at 7:45A m., from the causes and on the date stated above.

23a. SIGNATURE <u>[Signature]</u>	(Degree or title) <u>C. M.D.</u>	23b. ADDRESS <u>100 N. Sixth, Hannibal, Mo.</u>	23c. DATE SIGNED <u>11-28-55</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>11/29/55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Akers Chapel</u>	24d. LOCATION (City, town, or county) (State) <u>Pike County Illinois</u>
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DATE REC'D BY LOCAL REG. <u>11-29-55</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>	ADDRESS <u>Hannibal Missouri</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

NOV 29 1955

RECEIVED

MARION CO. HEALTH DEPT.

DATE FILED

NOV 29 1955

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 *H. Crawford Smith*

Licensed Embalmer No.. 3814..

P. O. Address.. Hannibal, Miss.

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.