

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-006625

STATE FILE NUMBER

Registration District No. 275 Primary Registration District No. 3053 Registrar's No. 24

1. PLACE OF DEATH a. COUNTY <u>Phelps</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>City</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rolla</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Louis</u> <u>2129</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Phelps Co. Memorial</u>		Length of stay in lb <u>DOA</u>	d. STREET ADDRESS (If outside, give location) <u>4633 Westminster</u>
3. NAME OF DECEASED (Type or print) <u>KATHRYN DOYLE LANNING</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>15</u> Year <u>1959</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 26, 1936</u>
9. AGE (In years last birthday) <u>22</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cofa Omer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Resturant</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>Roderick C. Doyle</u>	
13b. MOTHER'S MAIDEN NAME <u>Vera J. Johnson</u>		14. NAME OF HUSBAND OR WIFE <u>Kenneth Lanning</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no none</u>		16. SOCIAL SECURITY NO. <u>486-38-0091</u>	17. INFORMANT Address <u>Vera Doyle 4633 Westminster, St. Louis,</u> I.O. <u>6</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>Severe internal injuries</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Possible ruptured liver - Mangled right arm - deep laceration in flesh</u> DUE TO (c) <u>Automobile accident</u>			INTERVAL BETWEEN ONSET AND DEATH <u>? P.O.H. Hospital</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input checked="" 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.) <u>Auto overturned number of times</u>		
20c. TIME OF INJURY Hour <u>8:00</u> Minute <u>00</u> Month, Day, Year <u>2-15-59</u>	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>U.S. 66</u>		
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20f. CITY, TOWN, OR LOCATION <u>Rolla</u>	COUNTY <u>Phelps</u>	STATE <u>MO</u>
21. I attended the deceased from _____ to _____ and last saw her/him _____ Death occurred at <u>8 to 8:30</u> P m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>S. L. [Signature]</u> (Degree or title)		22b. ADDRESS <u>Rolla Mo</u>	22c. DATE SIGNED <u>2/17/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>2-17-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Laurel Hill Memorial Garden</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>
24. FUNERAL DIRECTOR <u>Carl [Signature]</u>	ADDRESS <u>1103 Elm, Rolla, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Feb. 17, 1959</u>	26. REGISTRAR'S SIGNATURE <u>Nadine S. Stoll</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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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 ER., Student Embalmer No. working under my personal supervision.

Student Signature of Student Embalmer

Signed *Carl J. Glenn* Carl J. Glenn

Licensed Embalmer No. 4707

P. O. Address Rolla, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting. If this body is not embalmed, fact should be so stated above.

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