

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Registration District No. 325 Primary Registration District No. 4479 Registrar's No. 40

5. 300
y. 1-57

1. PLACE OF DEATH a. COUNTY <u>Schuyler</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>Cook</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Queen City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>La Grange</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>90</u>		Length of stay in 1b <u>3 mos 5 1/2 wks</u>	d. STREET ADDRESS (If outside give location) <u>641 So Wavela</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Louise</u> Middle <u>Fouts</u> Last <u>Lanher</u>			4. DATE OF DEATH Month <u>Oct</u> Day <u>21</u> Year <u>60</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 22 1917</u>		9. AGE (In years last birthday) <u>43</u>	10. UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	11. 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>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Queen City Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13a. FATHER'S NAME <u>Joshua L. Dooley</u>		13b. MOTHER'S MAIDEN NAME <u>Gladys Fouts</u>		14. NAME OF HUSBAND OR WIFE <u>O. D. Lanher</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (es, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>O. D. Lanher 6415 Wavela La Grange Ill.</u> Address:			

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>Uremia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Complete Kidney Failure</u>	<u>3 days</u>
	DUE TO (c) <u>Cerebral Hemorrhage</u>	<u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition stated in PART I (a) <u>Abnormally small left carotid artery</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

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.) <u>-</u>
20c. TIME OF INJURY Hour <u>-</u> Month <u>-</u> Day <u>-</u> Year <u>-</u> a.m. <u>-</u> p.m. <u>-</u>	

20d. INJURY OCCURRED WHILE AT <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.) <u>-</u>	20f. CITY, TOWN, OR LOCATION <u>-</u>	COUNTY <u>-</u>	STATE <u>-</u>
21. I attended the deceased from <u>7/29/60</u> to <u>10/21/60</u> and last saw her <u>glie</u> on <u>10/21/60</u> Death occurred at <u>6:00 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE <u>Edward M. Roberts, M.D.</u> (Doctor or nurse)	22b. ADDRESS <u>Queen City, Mo.</u>	22c. DATE SIGNED <u>10/22/60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>Oct 23 '60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Queen City Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Queen City Mo</u>

24. FUNERAL DIRECTOR <u>Dooley Funeral Home</u>	ADDRESS <u>Queen City, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>10-22-60</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. P. J. Baker</u>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
cancer, cholera, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

MEDICAL CERTIFICATION

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 *Thos E Foster*

Licensed Embalmer No. *4942*

P. O. Address *Ferrisville, 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.