SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

TMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5435 -61-022827 STATE FILE NUMBER

FILED JUL 13 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

1. PLACE OF DEATH
a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St.Louis — Length of stay in 1b

c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Enroute City Hospital — Inside Limits: Yes [X] No [ ]

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY

c. CITY OR TOWN: St.Louis — Inside Limits: Yes [X] No [ ]

d. STREET ADDRESS (If outside, give location): 1014 Locust St. — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First John, Middle Henry, Last Lanning

4. DATE OF DEATH: Month June, Day 8, Year 1961

5. SEX: Male

6. COLOR OR RACE: White

7. Married [ ] Never Married [X] Widowed [ ] Divorced [ ]

8. DATE OF BIRTH: 9/8/1874

9. AGE (last birthday): 86 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HR: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (City and state or country): Bloomsdale,Mo.

12. CITIZEN OF WHAT COUNTRY: U.S.

13a. FATHER'S NAME: Richard F.Lanning

13b. MOTHER'S MAIDEN NAME: Elizabeth Gammel

14. NAME OF HUSBAND OR WIFE: None

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) Spanish American

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Dr.R.Lanning, Address: Ste.Genevieve,Mo.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).

PART I. DEATH WAS CAUSED BY: — INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a): Arterio Sclerotic Heart disease.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b): Arterio Sclerosis.

DUE TO (c): 420.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days. [ ] Yes [ ] No [ ] Unknown

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION — COUNTY — STATE

21. I attended the deceased from _____, to _____ and last saw her/him alive on _____

Death occurred at 7 15 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree of title): Paul J Simon Deputy Coroner

22b. ADDRESS: 1300 Clark

22c. DATE SIGNED: 6/10/61

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE: 6-11-61

23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery

23d. LOCATION (City, town, or county) (State): Valle Springs,Mo.

24. FUNERAL DIRECTOR — ADDRESS: Stanton Funeral Home, Ste.Genevieve,Mo.

25. DATE RECD. BY LOCAL REG.: JUN 10 1961

26. REGISTRAR'S SIGNATURE: Hoad Smith. M.D.

AUG 11 1961

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 Stanley W. Dixon

Licensed Embalmer No. 4193

P. O. Address St Louis, 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.