

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 14410
1837

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

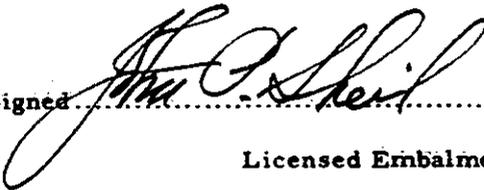
1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u>		
b. CITY (If outside corporate limits, write RURAL and give township) <u>KANSAS CITY</u>		c. LENGTH OF STAY (in this place) <u>35 yrs</u>	c. CITY OR TOWN <u>KANSAS CITY</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>6402-E-12th ST</u>			e. STREET ADDRESS (If rural, give location) <u>6402-E-12th ST 3208</u>		
3. NAME OF DECEASED (Type or Print) a. (First) <u>PAUL</u> b. (Middle) <u>ORSCHELN</u> c. (Last) <u>ORSCHELN</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>4-2-53</u>		
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>7-9-1878</u>	9. AGE (In years last birthday) <u>74</u>	10. UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT (RETIRED) GROCERY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GROCERY</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>LOOSE CREEK Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>KARL O. ORSCHELN</u>		13b. MOTHER'S MAIDEN NAME <u>JOSEPHENE SCHMITZ</u>		14. NAME OF HUSBAND OR WIFE <u>ANNA SHARP ORSCHELN</u>	
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>496-03-2567</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs Anna Orscheln 6402-E-12th St</u>		
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral thrombosis, Ruptured capsule</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Arteriosclerotic Heart disease with auricular fibrillation</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>years</u> <u>332X</u> <u>7 years</u>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3-5, 1953</u> , to <u>4-3, 1953</u> , that I last saw the deceased alive on <u>3-27, 1953</u> , and that death occurred at <u>3:30 A.M.</u> , from the causes and on the date stated above.					
23a. SIGNATURE <u>Richard W. Gunn</u>			23b. ADDRESS <u>M.D. 6230 Truman Rd K.C. Mo</u>	23c. DATE SIGNED <u>4-3-1953</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>4-6-53</u>	24c. NAME OF CEMETERY OR CREMATORY <u>FLORAL HILLS</u>	24d. LOCATION (City, town, or county) (State) <u>KANSAS CITY Mo</u>		
DATE REC'D BY LOCAL REG. <u>4-4-53</u>	REGISTRAR'S SIGNATURE <u>Geraldine Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>John P. Keith K.C. Mo</u>		

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

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 

Licensed Embalmer No. 25625

P. O. Address H. C. Seil

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.