

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **42874**
5735

FILED DEC 23 1953

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

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) Kansas City	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph Hospital		d. STREET ADDRESS (If rural, give location) 75 5246 Woodland Avenue	

3. NAME OF DECEASED (Type or Print) EMIL E. EHRECKE	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH 12/3/53	(Month)	(Day)	(Year)
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 12/19/1880	9. AGE (In years last birthday) 72	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 HRS. Hours	IF UNDER 1 HRS. Mins.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED 2 YRS INSTRUCTOR	10b. KIND OF BUSINESS OR INDUSTRY ART SCHOOL	11. BIRTHPLACE (City and State or Foreign Country) GERMANY	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME UNKNOWN EHRECKE	13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE Alta M. Ehrecke
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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) No	16. SOCIAL SECURITY NO. 487-01-9612	17. INFORMANT'S SIGNATURE OR NAME Mrs. ALTA M. EHRECKE	ADDRESS 5246 WOODLAND KANSAS CITY MO.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) Chronic myelogenous leukemia		INTERVAL BETWEEN ONSET AND DEATH 2041
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic myelogenous leukemia		
ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) _____ rise to the above cause (a) stating the underlying cause last. DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, **PAST HOSPITAL**, and that death occurred at **12:15Am.**, from the causes and on the date stated above.

23a. SIGNATURE Russell W. Kerr M.D. (Degree or Title)	23b. ADDRESS St. Joseph Hospital, K. C. Mo.	23c. DATE SIGNED 12-3-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE DEC-7-1953	24c. NAME OF CEMETERY OR CREMATORY MT. MORIAH CEMETERY	24d. LOCATION (City, town, or county) (State) KANSAS CITY MISSOURI
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DATE REC'D BY LOCAL REG. 12-7-53	REGISTRAR'S SIGNATURE Geraldine Smith	25. FUNERAL DIRECTOR'S SIGNATURE H. A. Newcomer	ADDRESS 1731 Birch Creek Kansas City Missouri
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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
Student Embalmer

Signed

Clare V. Carr

Licensed Embalmer No. 4934

P. O. Address K.C. 10, 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 this body is not embalmed, fact should be so stated above.