

Health, Welfare, Public Service  
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 -56  
 Doctor, coroner, etc. must use only standard notations in Part I. No symptoms with no disease. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

THE DIVISION OF REALTY OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

FILED JAN 22 1957

44720  
 STATE FILE NUMBER 5703

Registration District No. 149 Primary Registration District No. 1005 Registrar's No.

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>KANSAS City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>6006 HARRISON ST.</b>		Length of stay in <b>9 YEARS</b>	d. STREET ADDRESS <b>6006 HARRISON</b>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>EDITH</b> Middle <b>J.</b> Last <b>TRAHERN</b>			4. DATE OF DEATH <b>DECEMBER-29-1956</b> Month Day Year		
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOVEMBER 19, 1882</b>	9. AGE (In years last birthday) <b>74</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>DUFF &amp; REPP FURNITURE STORE</b>	11. BIRTHPLACE (City and state or country) <b>KANSAS City, MISSOURI</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>JACOB B. TRAHERN</b>			14. MOTHER'S MAIDEN NAME <b>LIDIA J. WOODWARD</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>486-01-5737</b>	17. INFORMANT Address <b>MRS. ETHEL RENARD, 6006 HARRISON, K.C. Mo.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Adenocarcinoma—</b> <b>Retroperitoneal &amp; Hepatic.</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>(Primary site undetermined at Surgery)</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (n)					INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>  <b>1948</b>
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.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year					
20d. INJURY OCCURRED WHILE AT WORK <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.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <b>Sept. 1956</b> , to <b>29 Dec. 1956</b> and last saw <b>(him)</b> alive on <b>28 Dec. 1956</b> Death occurred at <b>11:15</b> A. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Philip G. Kaul M.D.</b>			22b. ADDRESS <b>411 Nichols Road</b>		22c. DATE SIGNED <b>30 Dec. 56</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>DEC. 31, 1956</b>	23c. NAME OF CEMETERY OR CREMATORY <b>FOREST Hill CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>KANSAS City Missouri</b>
24. FUNERAL DIRECTOR <b>D.W. NEWCOMER'S SONS, KANSAS City, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>12-31-56</b>		26. REGISTRAR'S SIGNATURE <b>Dwain Marshall</b>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
 Philip G. Kaul

MEDICAL CERTIFICATION

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

Student.....  
Signature of Student Embalmer

Signed *Robert Kay*.....

Licensed Embalmer No. *418*

P. O. Address *K.C., Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.