

STANDARD CERTIFICATE OF DEATH

31982
STATE FILE NUMBER
3973

FILED SEP 19 1957

Registration District No. 149 Primary Registration District 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, give TOWNSHIP only) KANSAS CITY | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN KANSAS CITY | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION VA HOSPITAL | | Length of stay in lb 44 years | d. STREET ADDRESS (If outside, give location) 6134 OAK | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First THEODORE Middle W. Last LASCH | | | 4. DATE OF DEATH Month August Day 22 Year 1957 | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Nov. 15, 1880 | 9. AGE (In years last birthday) 76 | IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) Lincoln, Nebraska | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13a. FATHER'S NAME Theodore F. Lasch | | 13b. MOTHER'S MAIDEN NAME Jennie Jackson | | 14. NAME OF HUSBAND OR WIFE Myrtle Lasch | |
| 15. WAS DECEASED EVER IN U. S. ARMY, NAVY, AIR FORCE, MARINE CORPS, OR COAST GUARD? (Yes, no, or unknown) (If yes, give year or dates of service) Yes SAW | | 16. SOCIAL SECURITY NO. 488 01 2233 | 17. INFORMANT Address VA Hospital Official Records, K. C. Mo. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exsanguination | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | 451+ |
| DUE TO (b) Massive retroperitoneal hemorrhage | | | | | |
| DUE TO (c) Ruptured aortic arteriosclerotic aneurysm | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). Emphysema of the lungs | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 Month, Day, Year a.m. p.m. | | | | | |
| 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.) | | 20f. CITY, TOWN, OR LOCATION COUNTY STATE | |
| 21. I attended the deceased from August 22, 1957 to August 22, 1957 Death occurred at 8:58 PM on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE A. J. Williams J. WILLIAMS, M.D. | | | 22b. ADDRESS U. a. Hoop, K. C. Mo. | | 22c. DATE SIGNED |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 8-26-1957 | 23c. NAME OF CEMETERY OR CREMATORY Floral Hills | | 23d. LOCATION (City, town, or county) (State) Kansas City, Missouri |
| 24. FUNERAL DIRECTOR FLORAL HILLS MEMORIAL CHAPELS INC K.C.MO | | 25. DATE RECD. BY LOCAL REG. 8-24-57 | | 26. REGISTRAR'S SIGNATURE, Neva Marshall | |

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

MEDICAL CERTIFICATION



STATE OF

MISSISSIPPI

THE BOARD OF

HEALTH OFFICIALS

HEALTH OFFICIALS

STATE OF

MISSISSIPPI

STATE OF MISSISSIPPI

HEALTH

OFFICIALS

OF THE BOARD OF HEALTH OFFICIALS

STATE

OF

MISSISSIPPI

HEALTH OFFICIALS

STATE

HEALTH OFFICIALS

STATE OF MISSISSIPPI

HEALTH OFFICIALS

STATE OF MISSISSIPPI

HEALTH OFFICIALS

STATE

HEALTH OFFICIALS

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. 3938

P. O. Address _____

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.