

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

40184

STATE FILE NUMBER

5313

FILED DEC 2 - 1957

Registration District No. 149 Primary Registration District No. 1002

Registrar's No. 5313

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>5025 GLENSIDE DR.</b>		Length of stay in lb <b>45 yrs.</b>	d. STREET ADDRESS (If outside, give location) <b>3933 CAMPBELL STREET</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>EDWARD</b> Middle <b>B.</b> Last <b>AURICH</b>			4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>10</b> Year <b>1957</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUGUST 14, 1887</b>	9. AGE (In years last birthday) <b>70</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>
IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED - METER REPAIRMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>GAS COMPANY</b>	11. BIRTHPLACE (City and state or country) <b>WOODLAND, ILLINOIS</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>CHARLES E. AURICH</b>		13b. MOTHER'S MAIDEN NAME <b>ANNA BERTRAND</b>		14. NAME OF HUSBAND OR WIFE <b>ALICE V. AURICH</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>487.10.4222</b>	17. INFORMANT Address <b>MRS. ALICE V. AURICH, 3933 CAMPBELL, 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>Carcinoma of the</b>					INTERVAL BETWEEN ONSET AND DEATH <b>14 months</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Carcinoma of Right Lung</b>				<b>15 months</b>
	DUE TO (c) <b>Chronic Bronchitis</b>				<b>15 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Cor Pulmonale -</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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 _____ Month, Day, Year _____ a.m. _____ p.m. _____					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, mine, drug, etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
21. I attended the deceased from <b>9-27-56</b> to <b>11-10-57</b> and last saw him alive on <b>10-11-1957</b> Death occurred at <b>9:30 A.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>Graham Asher M.D.</b> (Degree or title)			22b. ADDRESS <b>1220 Professional Bldg. Kansas City, Mo</b>		22c. DATE SIGNED <b>11-11-57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>NOV. 12, 1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MT. MORIAH 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>11-12-57</b>	26. REGISTRAR'S SIGNATURE <b>Neva Minshall</b>		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Graham Asher

2

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 Chester K Brown

Licensed Embalmer No. 493  
P. O. Address KO 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.