

FILED JAN 26 1945

Registration District No. 189

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: K. C. General Hospital No. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8 days
(Specify whether years, months or days)

In this community 40 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 3520 Cherry
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country X

3. (a) PRINT FULL NAME Ray Brown Gaylord

3. (b) If veteran, name war Spanish American 3. (c) Social Security No. none

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Edna L. Gaylord 6. (c) Age of husband or wife if alive unknown years

7. Birth date of deceased November 2 1876
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>68</u>	<u>2</u>	<u>9</u>	hr. min.

9. Birthplace Kansas
(City, town, or county) (State or foreign country)

10. Usual occupation Contractor

11. Industry or business Retired

12. Name Ike Gaylord

13. Birthplace Ohio
(City, town, or county) (State or foreign country)

14. Maiden name Lillian Bailey

15. Birthplace New York
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Edna L. Gaylord

(b) Address 3520 Cherry, Kansas City, Mo.

17. (a) Burial (b) Date thereof 1-13-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Washington Cemetery

18. (a) Signature of funeral director Stine & McClure

(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) 1-13-45 (b) P. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 11
year 1945 hour 3 minute 30 A.M.

21. I hereby certify that I attended the deceased from Jan. 3 1945 to Jan. 11 1945
that I last saw him alive on Jan. 11 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Diabetes mellitus
Intracranial hemorrhage

Duration

Due to

Due to

Other conditions 61
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:
Of operations

Of autopsy None

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? A. E. Upsher (Specify type of case) (c) Means of injury MO

23. Signature A. E. Upsher (M. D. or other) MD
Address Med. Dir. Gen'l Hosp. Date signed 1-11-45

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

MOTHER FATHER

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed E M Plank

Licensed Embalmer No. FS 48

P. O. Address H. C. - 270

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.