FILED FEB 4 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 1454

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 254

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City — Inside Limits Yes X No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1640 Corrington — Length of stay in this place: 13 yrs

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Jackson
c. CITY OR TOWN Kansas City — Inside Limits Yes X No ☐
d. STREET ADDRESS 1640 Corrington (If outside, give location) — Reside on Farm Yes ☐ No X

3. NAME OF DECEASED (Type or print): First LEON Middle Last SAYLOR

4. DATE OF DEATH Month January Day 17 Year 1957

5. SEX Male **6. COLOR OR RACE** White **7. MARRIED** X **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐ **8. DATE OF BIRTH** May 12 1889 **9. AGE** (In years last birthday) 67 — 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 foreman
10b. KIND OF BUSINESS OR INDUSTRY Witte Engine works
11. BIRTHPLACE (City and state or country) Cross Timbers Missouri
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Samuel Saylor
14. MOTHER'S MAIDEN NAME No Record

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW 2
16. SOCIAL SECURITY NO. 431-09-4465
17. INFORMANT Address Mr William A Saylor 1640 Corrington

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of Prostata — INTERVAL BETWEEN ONSET AND DEATH 1953
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) ____ DUE TO (c) ____ — 177X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT ☐ **SUICIDE** ☐ **HOMICIDE** ☐
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 ☐ NOT WHILE AT WORK ☐
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 1953, to 17 Jan 1957 and last saw her/him alive on 1-17-57 8 P.M.
Death occurred at ____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE H. E. Carlson (Degree or title) M.D.
22b. ADDRESS 1316 Prof. Bldg
22c. DATE SIGNED 18 Jan 1957

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE Jan 21 1957
23c. NAME OF CEMETERY OR CREMATORY Mt Washington Cemetery
23d. LOCATION (City, town, or county) (State) Kansas City Missouri

24. FUNERAL DIRECTOR ADDRESS Sheil Funeral Home Kansas City Mo
25. DATE RECD. BY LOCAL REG. 1-18-57
26. REGISTRAR'S SIGNATURE Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in filling in diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FEB 7 1957

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Richard E. Carroll.

Licensed Embalmer No. 48

P. O. Address K. Omo

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