IRI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED OCT 13 1959

59-032422
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4580

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City — Length of stay in 1b: 25 Yrs
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4442 Bales — Inside Limits Yes X No ☐

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 (If outside, give location) 4442 Bales — Reside on Farm Yes ☐ No X

3. NAME OF DECEASED (Type or print): First LOUIS Middle F Last KAYLOR
4. DATE OF DEATH: Month 9 Day 19 Year 1959
5. SEX: Male
6. COLOR OR RACE: White
7. Married X Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 8 11 82
9. AGE (last birthday): 77 — IF UNDER 1 YEAR: Months Days — IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Trucker
10b. KIND OF BUSINESS OR INDUSTRY: Trucking
11. BIRTHPLACE (City and state or country): Rosiclare Illinois
12. CITIZEN OF WHAT COUNTRY: U. S. A
13a. FATHER'S NAME: Chas. Kaylor
13b. MOTHER'S MAIDEN NAME: Harriet Hamilton
14. NAME OF HUSBAND OR WIFE: Pearl M. Kaylor
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): X X X X
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: Mrs. Pearl M. Kaylor — Address: 4442 Bales

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Cardiac failure
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Cerebral hemorrhage — 4 hours
DUE TO (c) Arteriosclerosis — 4 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

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 9/19/59, to 9/19/59 and last saw him alive on 9/19/59
Death occurred at 3:50 p m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Leo Vogan (Degree or title) D.O.
22b. ADDRESS 4605 Independence Ave.
22c. DATE SIGNED 9/21/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE 9 22 1959
23c. NAME OF CEMETERY OR CREMATORY: Floral Hills
23d. LOCATION (City, town, or county) (State): Kansas City Missouri

24. FUNERAL DIRECTOR ADDRESS: Floral Hills Mem. Chapels, Inc K.C. MO
25. DATE RECD. BY LOCAL REG.: 9-21-59
26. REGISTRAR'S SIGNATURE: neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

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

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Forrest D. Coldanou

Licensed Embalmer No. #4714

P. O. Address Z. C. Mo

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