

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-045439

FILED VS DEC 19 1960

STATE FILE NUMBER

Registration District No. 393 Primary Registration District No. 1002 Registrar's No. 6147

ENDED

| | | | | | | | | | |
|--|--|---|--|--|---|--|--|----------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY <u>CLAY</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>CLAY</u> | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY, Mo. No.</u> | | Length of stay in 1b <u>9 yrs.</u> | | c. CITY OR TOWN <u>KANSAS CITY NORTH</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>8100 SUMMITT</u> | | | /Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <u>7700 MADISON</u> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>FORREST THEODORE SAILOR</u> | | | | 4. DATE OF DEATH Month Day Year <u>12-5-1960</u> | | | | | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH <u>3-30-1919</u> | 9. AGE (last birthday) <u>41</u> | IF UNDER 1-YEAR Months Days Hours Min. | IF UNDER 24 HR | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mo. STATE HIGHWAY DEPT</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>MAINTENANCE</u> | | 11. BIRTHPLACE (City and state or country) <u>GALLATIN, Mo.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | | |
| 13a. FATHER'S NAME <u>MACK SAILOR</u> | | | 13b. MOTHER'S MAIDEN NAME <u>VERNITA RAMSBOTTOM</u> | | | 14. NAME OF HUSBAND OR WIFE <u>BEULAH SAILOR</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>YES W.W.II</u> | | | 16. SOCIAL SECURITY NO. <u>495-26-0170</u> | | 17. INFORMANT Address <u>MRS. BEATRICE REAGER 700 E. 46TH No. K.C., Mo.</u> | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| IMMEDIATE CAUSE (a) | | | <u>Head injury multiple fractures</u> | | | | <u>2 DA</u> | | |
| DUE TO (b) | | | <u>2 Car accident</u> | | | | | | |
| DUE TO (c) | | | | | | | | | |
| 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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input checked="" 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 <u>4:30 p.m.</u> | Hour | Month, Day, Year <u>12/5/60</u> | | | | | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>8100 Summitt N.</u> | | 20f. CITY, TOWN, OR LOCATION <u>Kansas City</u> | | COUNTY <u>CLAY</u> | | STATE <u>MO</u> | |
| 21. I attended the deceased from _____ to _____ and last saw ^{her} him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | |
| 22a. SIGNATURE (Degree or title) <u>D. W. Newcomer M.D. Coroner</u> | | | | 22b. ADDRESS <u>North Kansas City Mo.</u> | | | | 22c. DATE SIGNED <u>12/16/60</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u> | 23b. DATE <u>12-7-1960</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>HILLCREST CEMETERY</u> | | 23d. LOCATION (City, town, or county) <u>GALLATIN, Mo.</u> | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS <u>D.W. NEWCOMER'S SONS N.K.C., Mo.</u> | | | | 25. DATE RECD. BY LOCAL REG. <u>12-6-60</u> | | 26. REGISTRAR'S SIGNATURE <u>H-L. Dwyer</u> | | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF S. Pate

DEC 19 1980

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Glen H. Hill

Licensed Embalmer No. 458

P. O. Address K.C. 18

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