

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

6411

1. PLACE OF DEATH

County Jackson
Towship Russ
City Kansas City

Registration District No. 339
Primary Registration District No. 5002

File No. _____
Registered No. 570
St. _____ Ward _____

2. FULL NAME

(a) Residence No. 1011 Park St. 14 Ward _____
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Maudie Wycoff

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 30 1887

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
47 0 4

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Conductor
(b) General nature of industry, business, or establishment in which employed (or employer) Miss Pa C
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Kansas
(STATE OR COUNTRY) _____

10. NAME OF FATHER Peter B. Wycoff

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Lava
(STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER Emperance Cooper

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Lava
(STATE OR COUNTRY) _____

14. INFORMANT Maudie Wycoff
(Address) 1011 Park

15. FILED 2-4-29 M M Crowe
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb - 4 1929

17. I HEREBY CERTIFY That I attended deceased from Oct. 13, 1928, to Feb. 4, 1929
that I last saw him alive on Feb 3, 1929, and that death occurred, on the date stated above, at 3:50 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Undifferentiated Tumor (Carcinoma)
4776

CONTRIBUTORY (SECONDARY) _____ (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH 1011 Park

DID AN OPERATION PRECEDE DEATH? No. DATE OF _____

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS autopsy findings

(Signed) J. E. Carver M. D.

Feb 4, 1929 (Address) 1001 Chambers St. 7th

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Atchinson Kans DATE OF BURIAL Feb. 6 1929

20. UNDERTAKER Mrs C. L. Forster ADDRESS 918 Brooklyn

1900
A. S. 1857

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County..... Registration District No. 399 File No.....
 Township..... Primary Registration District No. 1002 Registered No. 570
 City R. City (No.....) St. Ward)

2. FULL NAME

(a) Residence. No. St. Ward Charles Henry Wycoff
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

M W M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 20 - 1882

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
47 0 4

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....
 (b) General nature of industry, business, or establishment in which employed (or employer).....
 (c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN)..... (STATE OR COUNTRY).....

10. NAME OF FATHER.....

11. BIRTHPLACE OF FATHER (CITY OR TOWN)..... (STATE OR COUNTRY).....

12. MAIDEN NAME OF MOTHER.....

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)..... (STATE OR COUNTRY).....

14. INFORMANT..... (Address).....

15. FILED 94 29 M. M. Crowe REGISTRAR
user

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 4 1929

17. I HEREBY CERTIFY That I attended deceased from..... to....., 19....., that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Medical (Metastatic) Carcinoma

CONTRIBUTORY (SECONDARY) (duration)..... yrs..... mos..... ds.

18. WHERE WAS DISEASE CONTRACTED.....

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed)....., M. D.

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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