

WRITE IN ENGLISH—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

FEB 26 1940

Registration District No. 399

Primary Registration District No. 1002

State File No.

Registrar's No.

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 Trinity Lutheran Hosp.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution -- (Specify whether

In this community 2 1/2 years, months or days (Specify whether

3. (a) PRINT FULL NAME John Quincy Wycoff

8. (b) If veteran, name war World War 3. (c) Social Security No. 2

4. Sex M 5. Color or race W. 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Ella Jane Wycoff 6. (c) Age of husband or wife if alive years 19

7. Birth date of deceased 9 19 1885
(Month) (Day) (Year)

8. AGE: Years 54 Months 3 Days 17 If less than one day hr. min.

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

10. Usual occupation Lawyer

11. Industry or business

12. Name William Wycoff

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

14. Maiden name Kellie Crist

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

16. (a) Informant's own signature Ethel Graudon

(b) Address Westphalia, Kans.

17. (a) Burial (b) Date thereof 1/8/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Garnett, Kans.

18. (a) Signature of funeral director Stacy & McClure
(b) Address Kansas City, Mo.

19. (a) Jan. 7 1940 (b) M. M. Crome
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County _____

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

(d) Street No. _____ (If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 6
year 1940 hour 11 minute 10 A. M.

21. I hereby certify that I attended the deceased from Oct 30-1939
to Jan 6-1940
that I last saw him alive on Jan 6
and that death occurred on the date and hour stated above.

Immediate cause of death 1-2x myia
2- Gallstones

Due to 3- Ruptured aorta Monday 1/6/40
4- Peritonitis abscess

Due to _____

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

Major findings: _____

Of operations _____

Of autopsy _____

Duration _____

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) no.

(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? _____
(Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature W. H. Smith (M. D. or other) _____
Address Sanchez, Tex. Date signed _____

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.....

Licensed Embalmer No.....

P. O. Address.....

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, above space should be left blank.