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23159

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 33238

Registration District No. 79 FILED OCT 23 1940 Primary Registration District No. 3038 Registrar's No. 138

**1. PLACE OF DEATH:**

(a) County Saline

(b) City or town Marshall (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital ~~or institution~~ Fitzgibbons hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 10 days (Specify whether years, months or days)

In this community all her life

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo. (b) County Saline

(c) City or town Nelson (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.

3. (a) PRINT FULL NAME Mary Willie Wycoff

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex female

5. Color or race white

6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife ✓

6. (c) Age of husband or wife if alive ✓ years

7. Birth date of deceased April (Month) 27 (Day) 1899 (Year)

8. AGE: Years 41 Months 4 Days 9 If less than one day ___ hr. ___ min.

9. Birthplace Saline Co. (City, town, or county) Mo. (State or foreign country)

10. Usual occupation none

11. Industry or business ✓

FATHER
12. Name Willard Cranmore Wycoff
13. Birthplace (City, town, or county) Mo. (State or foreign country)

MOTHER
14. Maiden name Martha Harris
15. Birthplace Saline Co. (City, town, or county) Mo. (State or foreign country)

16. (a) Informant George Wycoff
(b) Address Slater, Mo.

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 9-8-1940 (Month) (Day) (Year)
(c) Place: burial ~~or cremation~~ Harris Cemetery

18. (a) Signature of funeral director Hill Brothers
(b) Address Slater-Mo.

19. (a) 9-7-40 (Date received local registrar) (b) Mary Kent Dep (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Sept. day 6th year 1940 hour 4 p m minute ___ M.

21. I hereby certify that I attended the deceased from Aug 27 1940 to Sept 6 1940 that I last saw her alive on Sept 6 1940 and that death occurred on the date and hour stated above.

| Immediate cause of death | Duration |
|---|---|
| Appendicial Abscess | 5 days |
| Due to Gangrenous appendix | 1 wk |
| Due to | |
| Other conditions (Include pregnancy within 3 months of death) Infantile Paralysis | 3 yrs |

Major findings: Of operations same as above

Of autopsy 121

PHYSICIAN

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) ✓
(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? 7 1/2 (Specify type of place)
While at work? ✓ (e) Means of injury ✓

23. Signature [signature] (M. D. or other)
Address Marshall Mo. Date signed 9/7/40

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 10-10-40

**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 Edgar Moore, Registered Apprentice No. 230 working under my personal supervision.

Signed Sam M Hill

Licensed Embalmer No. 1292

P. O. Address Slater Mo

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**