

FILED JAN 21 1950

 THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

 State File No. 43833
 5506

| | | | | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------|--|--|
| BIRTH NO. 86545-49 | | REG. DIST. NO. 149 | | PRIMARY REG. DIST. NO. 1002 | | Registrar's No. 5506 | | |
| 1. PLACE OF DEATH a. COUNTY JACKSON | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY CLAY | | | | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KANSAS City. | | c. LENGTH OF STAY (In this place) 36 hrs. | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Liberty. | | 10241 | | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Research Hospital. | | | | d. STREET ADDRESS (If rural, give location) 106 Groom. | | | | |
| 3. NAME OF DECEASED (Type or Print) Rebecca Sue Wyckoff | | | b. (Middle) Sue | | | c. (Last) Wyckoff | | |
| 4. DATE OF DEATH (Month) (Day) (Year) 12-8-49 | | 5. SEX Female | | 6. COLOR OR RACE White. | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married 1) | | |
| 8. DATE OF BIRTH 12-6-49 | | 9. AGE (In years last birthday) 12 | | IF UNDER 1 YEAR Months | | IF UNDER 24 HRS. Hour Min. 36 | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Kansas City, Missouri | | 12. CITIZEN OF WHAT COUNTRY U. S. A. | | |
| 13a. FATHER'S NAME Henry Edward Wyckoff | | | 13b. MOTHER'S MAIDEN NAME Evelyn Mae Jones | | | 14. NAME OF HUSBAND OR WIFE none | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. none | | 17. INFORMANT'S SIGNATURE OR NAME Mrs. Evelyn Wyckoff | | ADDRESS 106 Groom. | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Anoxia ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Premature Birth at Twenty Fourth week of pregnancy. DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | | INTERVAL BETWEEN ONSET AND DEATH 36 hrs | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION 776X | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | | 21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | | |
| 22. I hereby certify that I attended the deceased from 12-6-1949, to 12-8, 1949, that I last saw the deceased alive on 12-8, 1949, and that death occurred at 7:30 a.m., from the causes and on the date stated above. | | | | | | | | |
| 23a. SIGNATURE James W. Willoughby (Degree or title) James W. Willoughby, M.D. | | | | 23b. ADDRESS LIBERTY Mo. | | 23c. DATE SIGNED 12-26-49 | | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) cremated | | 24b. DATE 12.8.49 | | 24c. NAME OF CEMETERY OR CREMATORY Research Hospital | | 24d. LOCATION (City, town, or county) (State) 23rd & Holmes Mo. | | |
| DATE REC'D BY LOCAL REG. 12-28-49 | | REGISTRAR'S SIGNATURE Thaldine Holmes | | 25. FUNERAL DIRECTOR'S SIGNATURE Research Hosp. 23rd & Holmes | | ADDRESS | | |

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

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_____

Student Embalmer No. _____

working under my personal supervision.

Signed _____

Signed.....
Student Embalmer

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, fact should be so stated above.