

REC'D JUL 19 1939

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

23360  
Do not use this space.

1. PLACE OF DEATH

(a) County Saline Registration District No. 796  
(b) Township Marshall Primary Registration District No. 3038  
(c) City Marshall (d) Street No. \_\_\_\_\_ Registered No. 111  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Andrew Jacob Hayob  
(a) Residence, No. West Arrow st St.  (If nonresident, give city or town and State)

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 Anna Hayob  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 19 1878  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 60 6 4  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer  
9. Industry or business in which work was done, as saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year)  
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

FATHER 13. NAME HENRY Hayob

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

MOTHER 15. MAIDEN NAME Elizabeth Haig

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Hayden Indiana

17. INFORMANT (ADDRESS) Mrs. Andrew HAYOB Marshall, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Ridge Park DATE June 26 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Don Smart Marshall, Mo.

20. FILED 6-26-39 Ingrary Kent Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 23 1939  
22. I HEREBY CERTIFY, That I attended deceased from May 5 1939 to June 23 1939  
I last saw him alive on 6-23 1939. Death is said to have occurred on the date stated above, at 10 15 a.m.  
The principal cause of death and related causes of importance were as follows:

Carcinoma Pulvis Bone  
metastasis to skull  
Other contributory causes of importance: 57  
ea. of lung (metastatic) 37th

Name of operation none Date of \_\_\_\_\_  
What test confirmed diagnosis? X-ray & clinical Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.  
Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? no  
If so, specify \_\_\_\_\_  
(Signed) Robert Kennedy, M. D.  
Marshall Mo. (Address)

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.

RECEIVED  
District Health Officer No. 8,  
District File Number  
Date Filed 7/11/39

**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 *W. P. Cray*  
Licensed Embalmer No. 315-3  
P. O. Address Marshall Va

**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.**