

FILED SEP 12 1945

Registration District No. 334

Primary Registration District No. 3072

Registrar's No. 122

1. PLACE OF DEATH:

(a) County Saline  
 (b) City or town Marshall, Mo.  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
765 West Jackson St. /  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
 (Specify whether \_\_\_\_\_)  
 In this community 50 Years  
 (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Saline  
 (c) City or town Marshall  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 765 West Jackson  
 (If rural, give location)  
 (e) Citizen of foreign country? No. (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Sarah Jane Hanley

3. (b) If veteran, name war #  
 3. (c) Social Security No. #

4. Sex Female 5. Color or race White  
 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Michael R. Hanley  
 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased July I 1867  
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>78</u>	<u>I</u>	<u>I4</u>	hr. _____ min. _____

9. Birthplace County Mayo Ireland //  
 (City, town, or county) (State or foreign country)

10. Usual occupation House Wife

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name John Holmes

13. Birthplace County Mayo Ireland 4  
 (City, town, or county) (State or foreign country)

14. Maiden name Mary Ellen Hope

15. Birthplace County Mayo Ireland //  
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Mary E. Short

(b) Address Marshall, Mo.

17. (a) Burial (b) Date thereof 8/17/1945  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ridge P. Cemetery

18. (c) Signature of funeral director [Signature]

(b) Address Marshall, Mo.

19. (a) 8-16-45 (b) [Signature]  
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 15 year 45 hour 1 minute \_\_\_\_\_ A.M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 1945 to \_\_\_\_\_ 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis  
 Duration 5 yrs

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations [Signature]

Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

(Specify type of place) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

While at work \_\_\_\_\_

23. Signature [Signature] (M. D. or other) \_\_\_\_\_

Address [Address] Date signed 8/16/45

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

7.  
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RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 9-8-43.....

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..... *J. Leslie Swenson*.....

Licensed Embalmer No. 3235.....

P. O. Address Marshall, Mo......

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.