

Registration District No. 320

Primary Registration District No. 3072

Registrar's No. 49

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:
300 N. Miami Ave
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 yrs (Specify whether years, months or days)

3. (a) PRINT FULL NAME MARTIN VAN ANGLIN

3. (b) If veteran, name war _____ 3. (c) Social Security No. 500-10-7921

4. Sex M 5. Color or race W
6. (b) Name of husband or wife Fay Cotte Anglin 6. (c) Age of husband or wife if alive 26 years
7. Birth date of deceased Nov. 29 1903
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
43 2 29 hr. min.

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

10. Usual occupation Shoe Factory Employee

11. Industry or business

12. Name William R. Anglin
13. Birthplace Benton Co mo (City, town, or county) (State or foreign country)
14. Maiden name Martha E.
15. Birthplace Richmond mo (City, town, or county) (State or foreign country)

16. (a) Informant Fay Cotte Anglin
(b) Address Marshall mo

17. (a) Burial (b) Date thereof 3-2-1947
(Burial, cremation, or removal) (Month) (Day) (Year)
Sunset Memorial Gardens Marshall mo
(c) Place: burial or cremation

18. (a) Signature of funeral director Harry Hershberger
(b) Address Marshall mo

19. (a) 2-28-1947 (b) Hidney T. Gray
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County Saline
(c) City or town Marshall
(If outside city or town limits, write "RURAL")
(d) Street No. 300 N. Miami Ave
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 28
year 1947 hour 3 minute 55 A.M.

21. I hereby certify that I attended the deceased from 47 Feb 13 to 47 Feb 28
that I last saw him alive on 47 Feb 27
and that death occurred on the date and hour stated above

Immediate cause of death Lobar Pneumonia Duration 2 wks

Due to _____
Due to _____

Other conditions Chronic Bronchitis 60%
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy 100

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? _____

While at work? _____ (Specify type of place)
(c) Means of injury _____
23. Signature W. H. Hershberger (or other)
Address Marshall Date signed 2/28/47

RECEIVED
District Health Officer No. 8,
District File Number _____
Date Filed 3-26-47

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 _____

Harry Hershberger

Licensed Embalmer No. 4357

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.