

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: 560 W. Arrow  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community All Her Life  
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. 560 W. Arrow  
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Mrs. Anna E. Hayob

3. (b) If veteran, name war #

3. (c) Social Security No. #

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 18  
year 1947 hour 5 minute 30 P.M.

21. I hereby certify that I attended the deceased from May 15, 1947 to May 18, 1947  
that I last saw her alive on 5/18/47 and that death occurred on the date and hour stated above.

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

6. (b) Name of husband or wife Andy Hayob 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased January 22 1881  
(Month) (Day) (Year)

Immediate cause of death Hypertensive Cardio-vascular disease

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

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

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

8. AGE:	Years	Months	Days	If less than one day
	<u>66</u>	<u>3</u>	<u>27</u>	hr. _____ min. _____

9. Birthplace Unknown Indiana  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business !! !!

12. Name John Wise Sr.

13. Birthplace Alasce Lorraine Germany  
(City, town, or county) (State or foreign country)

14. Maiden name Anna Solomon

15. Birthplace Alasce Lorraine Germany  
(City, town, or county) (State or foreign country)

Major findings: Of operations 97

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

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Lawrence Kessler

(b) Address Marshall, Mo.

17. (a) Burial (b) Date thereof 5/21/47  
(Burial, cremation, or removal) (Month) (Day) (Year)

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? \_\_\_\_\_

(c) Place: burial or cremation Ridge Park Cemetery

18. (a) Signature of funeral director Wesley Burroughs

(b) Address Marshall, Mo.

19. (a) May 10th 1947 (b) Wesley Burroughs  
(Date received by Registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury? \_\_\_\_\_

23. Signature C. A. Veatch M.D. (M. D. or other)  
Address Marshall, Mo. Date signed 5/18/47

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

77  
1  
2

RECEIVED

District Health Officer No. 0,

District File Number.....

Date Filed 6-12-47

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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 Swamy*

Licensed Embalmer No. 3235

P. O. Address.....

*Marshall, Md*

**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.