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

Do not use this space.

8862

1. PLACE OF DEATH

County..... Registration District No. 781

Township..... Primary Registration District No. 1003

City St Louis (No. 5968 Horton Place St. Ward)

File No. 2330

Registered No.

2. FULL NAME Thomas Marion

(a) Residence. No..... St., 5 Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Emily Marion

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 10 1848

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
80	2	14	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Fireman

(b) General nature of industry, business, or establishment in which employed (or employer) St Louis Fire Dept

(c) Name of employer

183

9. BIRTHPLACE (CITY OR TOWN).....
(STATE OR COUNTRY) Ireland

15

PARENTS

10. NAME OF FATHER John Marion

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY) Ireland

15

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY) Ireland

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14. INFORMANT John J Marion
(Address) 4148 Maffitt Ave

15. FEB 26 1929 Filed....., 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

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16. DATE OF DEATH (MONTH, DAY AND YEAR) 2/24 1929

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..... to ....., 19..... that I last saw him alive on Feb 23, 19 29, and that death occurred, on the date stated above, at 5 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

131 Myocarditis Chronic
94A
932 (duration)..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Chronic Myocarditis Arteriosclerosis
Chronic Interstitial Nephritis (duration) ? yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED? 134a
IF NOT AT PLACE OF DEATH?.....

O DID AN OPERATION PRECEDE DEATH? No. DATE OF.....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) J. A. Farr, M. D
, 19 29 (Address) Monty Chuff Bldg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Calvary

DATE OF BURIAL 2-27 1929

20. UNDERTAKER Arthur J Donnelly

ADDRESS 2039 Wash St

NOTE: Every item of information should be carefully supplied. ALL 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.

[illegible]

Economy Club Lect

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