

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

Do not use this space.

842

FEB 18 1936

1. PLACE OF DEATH
 County Franklin Registration District No. 295
 Township Miamie Primary Registration District No. 4179
 City Sullivan No. _____ St. _____ Ward _____

2. FULL NAME Walter Orlando Marion

(a) Residence, No. _____ St. _____ Ward _____
 (Usual place of abode) _____
 Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (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) Mary Marion

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 3, 1883

7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>52</u>	<u>6</u>	<u>29</u>	

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Electrician

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____

10. Date deceased last worked at this occupation (month and year) 1935 Total time (years) spent in this occupation 3

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

13. NAME Thomas Marion

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

15. MAIDEN NAME Lucinda Sullivan

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Penn.

17. INFORMANT Jess Marion
 (ADDRESS) Sullivan Mo

18. BURIAL, CREMATION, OR REMOVAL
 PLACE Chapel DATE Jan 4 1936

19. UNDERTAKER Chas. Shaffer
 (ADDRESS) Sullivan Mo

20. FILED 1/18 1936 C. A. Boster
 Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 2 1936

22. I HEREBY CERTIFY That I attended deceased from May 1934 to Jan 2 1936
 I last saw him alive on Jan 2 1936 Death is said to have occurred on the date stated above, at 4:30 A.M.
 The principal cause of death and related causes of importance were as follows:
Chronic Nephritis Date of onset ?
Chronic Interstitial Nephritis 3 yrs

Other contributory causes of importance _____

Name of operation _____ Date of _____
 What test confirmed diagnosis? Clin 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) W. J. West, M. D.
 (Address) Sullivan Mo

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

