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

I[illegible]TMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 7 1943

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 42244

Registration District No. 30-8 Primary Registration District No. 6196 Registrar's No. 30

1. PLACE OF DEATH:
(a) County: Texas
(b) City or town: Shirell Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days)
In this community ____

2. USUAL RESIDENCE OF DECEASED: 107
(a) State: Mo (b) County: Texas 0
(c) City or town: Rural Shirell 0
(If outside city or town limits, write "RURAL")
(d) Street No. ____
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME: William Edward Marion
3. (b) If veteran, name war ____
3. (c) Social Security No. ____
4. Sex: Mall
5. Color or race: White
6. (a) Single, widowed, married, divorced: /
6. (b) Name of husband or wife: Mary Marion
6. (c) Age of husband or wife if alive: 49 years
7. Birth date of deceased: Sept. 24 (Month) 1902 (Day) (Year)

8. AGE: Years 40 Months 2 Days 19 If less than one day ____ hr. ____ min.

9. Birthplace: Hennessey (City, town, or county) Okla. (State or foreign country) /
10. Usual occupation: Farmer
11. Industry or business: Gen Farming
MOTHER FATHER
12. Name: Guy Marion
13. Birthplace: Utica N.Y. (City, town, or county) / (State or foreign country)
MOTHER
14. Maiden name: Anna Hehling
15. Birthplace: Ill. (City, town, or county) / (State or foreign country)
16. (a) Informant: Mary Marion
(b) Address: Kiowa N
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 12-14-42 (Month) (Day) (Year)
(c) Place: burial or cremation: Hutchinson Cem
18. (a) Signature of funeral director: Smith & Ferguson
(b) Address: Licking Mo.
19. (a) 12-26-42 (Date received local registrar) (b) Maggie Wilson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 13 day Dec year 1942 hour 1 p minute 30' M.
21. I hereby certify that I attended the deceased from 1940, 19__, to Dec 13, 1942
that I last saw h. alive on Dec 13 1, 1942
and that death occurred on the date and hour stated above.

Immediate cause of death: T.B. / — Duration
Due to ____
Due to ____
Other conditions (Include pregnancy within 3 months of death) ____
Major findings: Of operations ____
Of autopsy ____

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): no
(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)
While at work? / (e) Means of injury ____
23. Signature: Joshua Gardner (M. D. or other)
Address: Licking Mo. Date signed ____

123 1 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8
District File Number 1436
Date Filed 1-6-43

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.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 42247

Registration District No. 353 Primary Registration District No. 6146 Registrar's No. 30

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

1. PLACE OF DEATH:

(a) County: Texas

(b) City or town: (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town (If outside city or town limits, write "RURAL")

(d) Street No. (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME: William Edward Marion

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex: M

5. Color or race: W

6. (a) Single, widowed, married, divorced: M

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased: Sept (Month) 24 (Day) 1898 (Year)

8. AGE: Years 40 Months 2 Days If less than one day hr. min.

9. Birthplace: (City, town, or county) Okla (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

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

14. Maiden name

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct Day 3 year 1942 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19; that I last saw him alive on 19; and that death occurred on the date and hour stated above.

Immediate cause of death: J.B. Cutmiary

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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) no

(b) Date of occurrence no

(c) Where did injury occur? no (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) none

While at work? (e) Means of injury

23. Signature: Lulu Randall (M. D. or other)

Address: Lufkin Tex Date signed 2-13-43

SUPPLEMENTARY