

MED JUL 13 1945

State File No. _____

Registration District No. 175

Primary Registration District No. 3036

Registrar's No. 66

1. PLACE OF DEATH:

(a) County Lawrence
(b) City or town Aurora
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
117 W Delta St
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lawrence
(c) City or town Aurora
(If outside city or town limits, write "RURAL")
(d) Street No. 117 W, Delta St
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Franklin M Marion

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Harriett Marion 6. (c) Age of husband or wife if alive 70 years
7. Birth date of deceased Jan 23 1875
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>70</u>	<u>4</u>	<u>26</u>	hr. _____ min.

9. Birthplace ? Ill.
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Farmer

11. Industry or business _____

12. Name Johnston Marion
13. Birthplace ? England
(City, town, or county) (State or foreign country)
14. Maiden name Harriett Collal
15. Birthplace ? Ind
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Harriett Marion
(b) Address Aurora Mo

17. (a) Burial (b) Date thereof 6/20/45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Aurora Mo

18. (a) Signature of funeral director J. F. King
(b) Address Aurora Mo

19. (a) 6-20-45 (b) Clinice [Signature]
(Data received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 18
year 1945 hour 1 minute 45 P.M.

21. I hereby certify that I attended the deceased from June 1
1945 to June 18 1945

that I last saw h. im alive on June 14
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis
Duration _____

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) None

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) _____
(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)
(e) Means of injury _____

23. Signature [Signature] (M. D. or other) _____
Address Aurora Mo Date signed June 21/45

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

5-1-39

RECEIVED

District Health Officer No. 6,

District File Number 745-762

Date Filed JUL 11 1945

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 *Herman Purridge*

Licensed Embalmer No. 3072

P. O. Address *Aurora 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.