

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.

OCT 22 1932

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

Do not use this space.

29752

1. PLACE OF DEATH

County Jackson Registration District No. 1308  
Township Haw Primary Registration District No. 1300  
City Hannas City (No. \_\_\_\_\_) \_\_\_\_\_

File No. \_\_\_\_\_  
Registered No. 3765  
St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Mrs. Cora May Walton

(a) Residence, No. T.W. Concord St. \_\_\_\_\_ 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 female 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 widow W. E. Walton

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) unknown

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
abt. 75

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.  
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) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

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

13. NAME M. M. Allen

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Marion Ohio

15. MAIDEN NAME Mary J. Allen

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

17. INFORMANT C. A. Allen (ADDRESS) Butler, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Butler, Mo. DATE \_\_\_\_\_ 19 \_\_\_\_\_

19. UNDERTAKER Oulvers (ADDRESS) Butler, Mo.

20. FILED Sept 30 19 35 M. M. Crone Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9/29 19 35

22. I HEREBY CERTIFY, That I attended deceased from Feb. 1933, to 9/29 1935

I last saw her alive on Sept 24 1935. Death is said to have occurred on the date stated above, at 1:30 p. m.

The principal cause of death and related causes of importance were as follows:

Carcinoma of Breast (Date of onset 1930!?)

Other contributory causes of importance: Multiple Metastases to Lungs, Brain, + Skin

Name of operation Op. of Breast Date of 1932  
What test confirmed diagnosis \_\_\_\_\_ 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) Edward H. Washington M. D.  
(Address) 1500 Poplarville Bldg.

