

S. No. 2
 M-5-43
 v. 17-39
 I X36671

THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. 9569
 Registrar's No. 3123

FILED APR 13 1944
 Registration District No. 318

Primary Registration District No. 1003

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

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:
De Paul Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 9 days
(Specify whether years, months or days)

In this community 35 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
17

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
9 6

(d) Street No. 2917 Abner Place
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)
 If yes, name country 0

3. (a) PRINT FULL NAME LUCRETIA J. WALTON

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife William Robert Walton

6. (c) Age of husband or wife if alive 66 years

7. Birth date of deceased: 12 27 1875
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

68 3 5 hr. min.

9. Birthplace Cavington Kentucky
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER, FATHER {

12. Name Henry Jonas

13. Birthplace Unknown Germany 4
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant William R. Walton

(b) Address 2917 Abner Place

17. (a) Burial (b) Date thereof 4-4-1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Cemetery

18. (a) Signature of funeral director Uelandert Sain

(b) Address 6175 Delmar Boulevard

19. (a) APP 2 (b) J. F. Brudeck
(Date received from Registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 2
 year 1944 hour 1:30 minute A M.

21. I hereby certify that I attended the deceased from June 1, 1936, to Apr 2, 1944
 that I last saw him alive on Apr 2, 1944
 and that death occurred on the date and hour stated above.

Immediate cause of death Diabetes Mellitus Diabetic Coma
 Duration 4 yrs 8 hours

Due to _____

Due to _____

Other conditions Divericulitis, Bronchitis
(Include pregnancy within 3 months of death)

Major findings: Infected Diverticulitis

Of operations _____

Of autopsy _____

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? _____

Where at _____? (Specify type of place)

(c) Means of injury _____

23. Signature W. Simpson (M. D. or other) M.D.

Address 7803 Washington Date signed 4/4/44

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 *Jos. E. McCulloch*
Licensed Embalmer No. *2760*
P. O. Address *6190 Delmar*

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.

S. S. South