

S. No. 2  
M-2-43  
5-17-39  
P-1 X35657

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

*Stuehler* 2155  
State File No. \_\_\_\_\_

FILED JAN 20 1945/16  
Registration District No. \_\_\_\_\_

Primary Registration District No. 3020

Registrar's No. 109

36  
6  
2

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

1. PLACE OF DEATH:

(a) County Franklin

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

(c) Name of hospital or institution: St. Francis Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 days (Specify whether years, months or days)

In this community 3 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Franklin <sup>36</sup>

(c) City or town Washington Villa Ridge <sup>0</sup>  
(If outside city or town limits, write "RURAL")

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

(e) Citizen of foreign country? no (Yes or No)  
If yes, name country 2 yrs

3. (a) PRINT FULL NAME WILLIAM HOWARD WALTON

3. (b) If veteran, name war none

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 14th  
year 1944 hour 3:00 minute P.M.

21. I hereby certify that I attended the deceased from 5-5  
1944 to 12-14 1944  
that I last saw alive on 12-14 1944  
and that death occurred on the date and hour stated above.

4. Sex male 5. Color or race White

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

6. (b) Name of husband or wife Katherine Mae Walton

6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased: August 14 - 1883  
(Month) (Day) (Year)

Immediate cause of death

Coronary Thrombosis <sup>3 min</sup>

Due to Arteriosclerotic Cardio Vasculer disease <sup>3 yrs</sup>

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

61 4 0

9. Birthplace: Franklin, Missouri <sup>hr. min.</sup>  
(City, town, or county) (State or foreign country)

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.

10. Usual occupation Wall Driller

11. Industry or business \_\_\_\_\_

12. Name Richard Craver Walton

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

14. Maiden name Anna Pooley

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

16. (a) Informant Mrs. Howard Walton

(b) Address Villa Ridge - Mo

17. (a) Burial (b) Date thereof 12-18-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Louis, Mo.

18. (a) Signature of funeral director Otto Co.

(b) Address Washington, Mo.

19. (a) 12/16/44 (b) W. L. R. Brooks  
(Date received local registrar) (Registrar's signature)

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 B. J. Stuehler (M. D. or other) M.D.  
Address Union Date signed 12-15-44

1181

RECEIVED

District Health Officer No. 9

District File Number.....

Date Filed 1-18-45

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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 [Signature] ;

Licensed Embalmer No. 2464

P. O. Address Washington 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.