

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

No. 2
2-23
17-29
X35697

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS
FILED SEP 24 1946

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32314

State File No. _____

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **7821**

1. PLACE OF DEATH:

(a) County _____

(b) City or town **ST. LOUIS**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
3134 Vine Grove
(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 **MISSOURI** (b) County **000**

(c) City or town **ST. LOUIS** **10/17**

(d) Street No. **3134 VINE GROVE**
(If outside city or town limits, write "RURAL")
(If rural, give location) **9**

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

If yes, name country _____

3. (a) PRINT FULL NAME **HENRY WALTON**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex **MALE** 5. Color or race **COL**

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

6. (b) Name of husband or wife **FRANCIS WALTON**

6. (c) Age of husband or wife if alive **4 1/2** years

7. Birth date of deceased: **9** (Month) **4** (Day) **1889** (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month **SEPT.** day **9th**
year **1946** hour **8:30** minute _____ P. 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.

8. AGE:

Years	Months	Days	If less than one day
57	0	5	hr. _____ min. 0

Immediate cause of death **Coronary Thrombosis** Duration

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

9. Birthplace **ST. LOUIS** (City, town, or county) (State or foreign country)

10. Usual occupation **Janitor**

11. Industry or business _____

MOTHER FATHER

12. Name **HENRY WALTON**

13. Birthplace **ST. LOUIS** (City, town, or county) (State or foreign country) **Mo.**

14. Maiden name **EMMA Bryant**

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

16. (a) Informant **Blanche Walton**

(b) Address **3134 Vine Grove**

17. (a) _____ (b) Date thereof **9/13/46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Everard Cem**

18. (a) Signature of funeral director **A. F. Walton**

(b) Address **2707 Bradford**

19. (a) **SEP 10 1946** (b) **Blanche**
Date received local health officer (Registrar's signature)

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 **Alfred Perry** **Dep Coroner**
(M.D. or other)

Address **1300 Clark Ave** Date signed **9/10/46**

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 Arthur S. Hilliard

Licensed Embalmer No. 4221

P. O. Address 1154 Bayard Ave

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. Registration District No. 318Primary Registration District No. 1003Registrar's No. 7871

1. PLACE OF DEATH:

(a) County.....
(b) City or town ST. LOUIS
(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 whetherIn this community.....
years, months or days)3. (a) PRINT
FULL NAME Henry Walton3. (b) If veteran,
name war.....3. (c) Social Security
No.4. Sex m 5. Color or race B 6. (a) Single, widowed, married,
divorced married6. (b) Name of husband or wife Jessie (c) Age of husband or wife if
alive.....7. Birth date of deceased Sept 4
(Month) (Day) (Year)8. AGE: Years 57 Months 0 Days 0 If less than one day
hr. min. 9. Birthplace mo
(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

12. Name

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

14. Maiden name

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

13. (a) Signature of funeral director

(b) Address

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

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.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Day Minute M.
year 1946 (th) (day) (minute)21. I hereby certify that I attended the deceased from 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

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 sta-
tistically.

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..... (M. D. or other)

Address..... Date signed.....

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

SUPPLEMENTARY

561 10 1340

32314