

FILED DEC 2 1948

Registration District No. **1948**

Primary Registration District No. **8024**

Registrar's No. **71**

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

1. PLACE OF DEATH:

(a) County **Howard**

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

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

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

In this community **All her life**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Howard 45**

(c) City or town **Armstrong**
(If outside city or town limits, write "RURAL")

(d) Street No. **0**
(If rural, give location)

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

If yes, name country **--**

3: (a) PRINT FULL NAME **Cassandra Preston 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 **Widowed**

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

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

7. Birth date of deceased **September 17, 1870**
(Month) (Day) (Year)

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

78 1 22 hr. min.

9. Birthplace **Mt. Airy, Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business **At Home**

12. Name **James Scarlet Preston**

13. Birthplace **Unknown**

14. Maiden name **Sarah Smith**
(City, town, or county) (State or foreign country)

15. Birthplace **Mt Airy, Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs Perrin Cooper**

(b) Address **Higginsville, Missouri**

17. (a) **Burial** (b) Date thereof **11/12/48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Walnut Shade Cemetery**

18. (a) Signature of funeral director **Ralph A. Carr**

(b) Address **Fayette Missouri**

19. (a) **11-20-1948** (b) **Dorothy Ann Johnson**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **November** day **9th**
year **1948** hour **11:00** minute **P.** M.

21. I hereby certify that I attended the deceased from **June 1947**
to **Nov 9 1948**
that I last saw him alive on **Nov 9 1948**
and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic Cholelithiasis**

Duration **2 yrs.**

Due to **----**

Due to **----**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **127/11**

Of autopsy **----**

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? **----**

(e) Means of injury **----**

While at work? (Specify type of place) **----**

23. Signature **M. D. Shaw** (M. D. or other) **M.D.**

Address **Fayette, Mo** Date signed **11-13-48**

PHYSICIAN
Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 12-1-48

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 Ralph A Carr

Licensed Embalmer No. 3340

P. O. Address Saylto - 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.