

RECD MAR 13 1939

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

4829
Do not use this space.

751
1003

1. PLACE OF DEATH

(a) County Registration District No.
 (b) Township Primary Registration District No. Registered No. **1522**
 (c) City **St. Louis** (d) Street No. **BARNES HOSPITAL** St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. **5** mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME **Stonewall Jackson Walton**

(a) Residence, No. **8501 Page** St. **NR St. Louis Co., Mo.**
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **M** 4. COLOR OR RACE **W** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **MARRIED**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **REBECCA L. WALTON**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **AUG 11 1875**

7. AGE YEARS **63** MONTHS **6** DAYS **4** If LESS than 1 day, hrs. or min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **RETIRED**
 9. Industry or business in which work was done, as law mill, bank, etc. **ATTORNEY**
 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) **TROY MO.**

FATHER 13. NAME **ROBERT WALTON**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **UNKNOWN**

MOTHER 15. MAIDEN NAME **HELEN COPLIER**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **HAWK POINT MO.**

17. INFORMANT (ADDRESS) **MRS. S. J. WALTON 8501 PAGE**

18. BURIAL, CREMATION, OR REMOVAL PLACE **MONTGOMERY CITY MO.** DATE **2-19-39**

19. FUNERAL DIRECTOR (NAME) (ADDRESS) **PITMAN FUNERAL HOME WENTZVILLE MO.**

20. FILED **FEB 16 1939** **J. D. Bisher** Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **2-15-1939**

22. I HEREBY CERTIFY, That I attended deceased from **Sept. 20**, 19**38**, to **Feb. 15**, 19**39**

I last saw him alive on **Feb. 15**, 19**39**. Death is said to have occurred on the date stated above, at **12:53** pm.

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

BENIGN HYPERTROPHY PROSTATE Date of onset **1934**
CHRONIC BILAT. PYELONEPHRITIS **1938**

Other contributory causes of importance:

UREMIA

Name of operation **CYSTOSTOMY** Date of **OCT. 1938**

What test confirmed diagnosis? **CYSTOSCOPY** Was there an autopsy? **YES**

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) **H. H. Hopper**, M. D.
 (Address) **BARNES HOSPITAL**

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.

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.....

Licensed Embalmer No. 2941

P. O. Address.....

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, above space should be left blank.