

Registration District No. 764

Primary Registration District No. 200

Registrar's No. 1206

1. PLACE OF DEATH:

(a) County St Louis
(b) City or town Riverview Gardens
(c) Name of hospital or institution: 316 Scenic Dr.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution None
In this community Unknown
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town Riverview Gardens
(d) Street No. 316 Scenic Dr.
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME William T. Walton

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Sarah Walton neeLawn 6. (c) Age of husband or wife if alive 75 years

7. Birth date of deceased April 24, 1856
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
84 2 0 hr. min.

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

10. Usual occupation Carpenter

11. Industry or business _____

MOTHER FATHER { 12. Name James Monroe Walton

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

14. Maiden name Elizabeth McDonald

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

16. (a) Informant Mrs Sarah Walton

(b) Address 316 Scenic Dr. R.G.

17. (a) Burial (b) Date thereof 6/27/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Friedens Cemetery

18. (a) Signature of funeral director Math Hermann & Son

(b) Address 2161 East Fair Ave

19. (a) JUL 25 1940 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 24th
year 1940 hour 6:45 PM minute _____ M.

21. I hereby certify that I attended the deceased from July 16
1940, to June 20, 1940
that I last saw him alive on June 20, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Senile gangrene in both feet
Due to occlusion of arteries in feet.

Due to _____
Other conditions none
(Include pregnancy within 3 months of death)

Major findings: Of operations none
Of autopsy none

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) none
(b) Date of occurrence _____
(c) Where did injury occur? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

707
While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature Dr. H. F. Miller (M. D.)
Address 2410 N. Broadway St. Louis Date signed 6-25-40

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

Duration 2 1/2 yrs
PHYSICIAN
Underline the cause to which death should be charged statistically.

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.....

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.