

No. 2  
-1/47  
5-17-39

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH  
1003

State File No. **33120**  
Registrar's No. **8768**

**FILED OCT 4 1947**  
Registration District No. **318**

Primary Registration District No. ....

Registrar's No. ....

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: **St. Marys Infirmary**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **16 Days**  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County..... **MO**

(c) City or town **St. Louis**  
(If outside city or town limits, write "RURAL")

(d) Street No. **3329 Laclede Ave.**  
(If rural, give location)

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

If yes, name country.....

3. (a) PRINT FULL NAME **Mae Willie Walton**

3. (b) If veteran, name war **No**

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

4. Sex **Female** 5. Color or race **Col.**

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

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

7. Birth date of deceased **Nov. 17, 1914**  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **16** year **1947** hour **10** minute **15 P.** M.

21. I hereby certify that I attended the deceased from **Sept 3**, 19**47**, to **Sept 16**, 19**47** that I last saw h..... alive on..... and that death occurred on the date and hour stated above.

Immediate cause of death **Transverse Myelitis**

Due to **Syphilis**

Other conditions.....

Duration **5 weeks**

**3 yrs.**

PHYSICIAN

Underline the cause of which death should be charged statistically.

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

**32** **9** **29** ..... hr. .... min.

9. Birthplace **Holly Dale, Miss.**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Laundry Worker**

11. Industry or business.....

12. Name **Lodge Walton**

13. Birthplace **Hollandale, Miss.**  
(City, town, or county) (State or foreign country)

14. Maiden name **Roberta ?**

15. Birth **Hollandale, Miss.**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Barbra Jean Walton**  
(b) Address **3329 Laclede Ave.**

17. (a) **Burial** (b) Date thereof **Sept. 19, 1947**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Hollandale, Mississippi**

18. (a) Signature of funeral director **Wright's Funeral Home**  
(b) Address **3100 Easton Ave.**

19. (a) **SEP 18 1947** (b) **J. J. Beedeck**  
(Date received local registrar) (Registrar's signature)

Due to.....

Due to.....

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

Major findings:  
Of operations.....

Of autopsy.....

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....

(b) Date of occurrence.....

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?.....  
(Specify type of place)

While at work?..... (c) Means of injury.....

23. Signature **E. A. Leeg** (M. D. or other) **MD**  
Address **1536 Papin St.** Date signed **9/18/47**

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

MOTHER FATHER

SEP 18 1947

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 L. Hilliard

Licensed Embalmer No. 4221

P. O. Address 1154 Bayard

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.