

FILED OCT 22 1948

State File No. **32678**

Registration District No. **128**

Primary Registration District No. **5463**

Registrar's No. **883**

1. PLACE OF DEATH:

(a) County **Webster**
 (b) City or town **Webster**
 (c) Name of hospital or institution:
Fair Grove Rt. #2
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **14 Years**
 In this community **14 Years**
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Greene**
 (c) City or town **Fair Grove Rt. #2**
 (d) Street No. **Fair Grove Rt. #2**
 (e) Citizen of foreign country? **No**
 If yes, name country

3. (a) PRINT FULL NAME **Samuel Francis Walton**

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

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

6. (b) Name of husband or wife **Myrtle E. Walton** 6. (c) Age of husband or wife if alive **69** years

7. Birth date of deceased **August 8 1873**
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	75	2	5	hr. min.

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

10. Usual occupation **Carpenter**

11. Industry or business **Carpenter**

12. Name **P.M. Walton** 13. Birthplace **Virginia**
 (City, town, or county) (State or foreign country)

14. Maiden name **Lee Ann Keeney**

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

16. (a) Informant **Myrtle E. Walton (Wife)**

(b) Address **Fair Grove, Mo., Rt. #2**

17. (a) **Burial** (b) Date thereof **10-16-48**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **CEDAR BLUFF**

18. (a) Signature of funeral director **J.W. Klingner & Co.**
 (b) Address **Springfield, Missouri**

19. (a) **10-16-48** (b) **W. J. Handley**
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **13**
 year **1948** hour **8** minute **30 P.M.**

21. I hereby certify that I attended the deceased from **6/23 1948** to **10/2 1948**
 that I last saw him alive on **10/2 1948**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary disease 1 year**

Due to _____
 Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **None**
 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? _____

While at work? (Specify type of place) _____
 (Specify means of injury) _____
 23. Signature **R. H. Foubt** (M. D. or other) **M.D.**
 Address **Stafford, Mo.** Date signed **10/15/48**

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

MOTHER FATHER

100-71-100-100-100

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 *Walt Rhodes*
.....
Licensed Embalmer No. *4071*
P.O. Address *Springfield*

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Nov
Registrar's No. 883

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County Greene

(b) City or town Rural Jackson Twp.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Rt. #2, Fair Grove
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County Greene

(c) City or town Rural - Fair Grove
(If outside city or town limits, write "RURAL")

(d) Street No. Rt. #2
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Samuel F. Walton

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex m 5. Color or race w

6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____

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

7. Birth date of deceased aug 8
(Month) (Day) (Year)

8. AGE: Years 75 Months 2 Days _____ (if less than one day)
hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

15. Birthplace _____ (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 _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ year 1945 hour _____ minute _____ M.

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 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 _____ (M. D. or other) _____

Date signed _____

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

SUPPLEMENTARY

MOTHER FATHER

S-32678