

FILED DEC 6 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39404

State File No.

BIRTH NO. REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **10255**

1. PLACE OF DEATH
a. COUNTY **2707 Stoddard St.**
2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE **Missouri** b. COUNTY **St. Louis**

b. CITY (If outside corporate limits, write RURAL and give township) c. LENGTH OF STAY (In this place)
St. Louis **40 yrs**
c. CITY (If outside corporate limits, write RURAL and give township)
St. Louis

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
2707 Stoddard
d. STREET ADDRESS (If rural, give location)
2707 Stoddard Street

3. NAME OF DECEASED
a. (First) **Julia** b. (Middle) **Mae** c. (Last) **Walton**
4. DATE OF DEATH (Month) (Day) (Year)
Nov 26 1949

5. SEX **female** 6. COLOR OR RACE **colored** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **married**
8. DATE OF BIRTH **Sept. 15, 1888** 9. AGE (In years last birthday) Months Days Hours Min.
61 2 11

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **housewife**
10b. KIND OF BUSINESS OR INDUSTRY
Camden, Mo
11. BIRTHPLACE (State or foreign country)
U.S.A.
12. CITIZEN OF WHAT COUNTRY

13a. FATHER'S NAME **Washington Riffe** 13b. MOTHER'S MAIDEN NAME **unknown** 14. NAME OF HUSBAND OR WIFE **Albert F. Walton**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) **no**
16. SOCIAL SECURITY NO.
no
17. INFORMANT'S SIGNATURE OR NAME ADDRESS
A. F. Walton - 2707 Stoddard

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) **bronchopneumonia**
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) **asthma**
DUE TO (c)
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY?
YES NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify) 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
95c

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR
H. 3 A.M.

22. I hereby certify that I attended the deceased from **Oct 8, 1949** to **Nov 26, 1949**, that I last saw the deceased alive on **19**, and that death occurred at **12:30 P.M.** from the causes and on the date stated above.

23a. SIGNATURE **J. B. Craddock** (Degree or title) 23b. ADDRESS **1003 Phippsville** 23c. DATE SIGNED **Nov 28, 1949**

24a. BURIAL, CREMATION, REMOVAL (Specify) **burial** 24b. DATE **Nov. 1/49** 24c. NAME OF CEMETERY OR CREMATORY **Washington Park** 24d. LOCATION (City, town, or county) (State)
St. Louis County, Mo.

DATE REC'D BY LOCAL REG. **NOV 29 1949** REGISTRAR'S SIGNATURE **J. B. Craddock** 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
Dement & Son 2629-31 Cole St.

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

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed W. Claude Gordon

Licensed Embalmer No. 3489

P. O. Address 4575 Alder

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.