

FILED APR 29 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **14225**  
Registrar's No. **3647**

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		State File No. <b>14225</b>		Registrar's No. <b>3647</b>					
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo</b> b. COUNTY _____									
b. CITY OR TOWN <b>St Louis</b>		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <b>St Louis Mo</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>910 Ohio St</b>				e. STREET ADDRESS (If rural, give locality) <b>22 910 Ohio St 2270</b>									
3. NAME OF DECEASED (Type or Print) a. (First) <b>TOM</b>			b. (Middle) _____			c. (Last) <b>WALTON</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>APR 19-54</b>				
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>COL</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>		8. DATE OF BIRTH <b>NOV 26, 1878</b>		9. AGE (In years last birthday) <b>75</b>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 6 mos. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____				10b. KIND OF BUSINESS OR INDUSTRY <b>NIL</b>				11. BIRTHPLACE (City and State or Foreign Country) <b>TENN</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13a. FATHER'S NAME <b>Sam Walton</b>				13b. MOTHER'S MAIDEN NAME <b>Not Known</b>				14. NAME OF HUSBAND OR WIFE <b>Estell Walton</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Ym. no. or unknown) _____ (If yes, give war or dates of service) _____				16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <b>Estell Walton</b> ADDRESS <b>910 Ohio</b>							
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____  ANTECEDENT CAUSES DUE TO (b) <b>Cerebral Apoplexy</b> DUE TO (c) <b>Arterio sclerosis</b> Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.								INTERVAL BETWEEN ONSET AND DEATH _____			
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
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) <b>334X</b>								
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____									
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <b>4:30 P.</b> m., from the causes and on the date stated above.													
23a. SIGNATURE <b>Patrick E. Taylor</b> (Degree or title) <b>Coroner</b>				23b. ADDRESS <b>1300 Clark</b>				23c. DATE SIGNED <b>4.21.54</b>					
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		24b. DATE <b>Apr 23</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Oakdale</b>		24d. LOCATION (City, town, or county) (State) <b>Jennay Mo</b>							
DATE REC'D BY LOCAL REG. <b>APR 22 1954</b>		REGISTRAR'S SIGNATURE <b>J. Earl Smith M.D.</b>				25. FUNERAL DIRECTOR'S SIGNATURE <b>St Watson</b> ADDRESS <b>2769 Cherokee</b>							

5. Licensed Embalmer's Statement on Reverse Side)

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

No. 300  
10-48

**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.....  
Signature of Student Embalmer

Signed *S. J. Watson*  
Licensed Embalmer No. *2691*

P. O. Address *2769/2*

**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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.**