

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

29278  
STATE FILE NUMBER  
6859  
REGISTRAR'S NO.

FILED AUG 24 1956

318

1003

Registration District No. Primary Registration District No.

300  
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

|                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                              |                                                                                                                                                          |                                                                                                   |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>City</u>                                                                                                                                                                                                                                                                                                                                                         |                                                                                              | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>City</u>                  |                                                                                                   |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis 12, Mo.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                                                                                                                                                                                                       |                                                                                              | c. CITY OR TOWN <u>St. Louis 12, Mo.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                               |                                                                                                   |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>5936 Cates Ave.</u> Length of stay in 1b <u>81 yrs.</u>                                                                                                                                                                                                                                                             |                                                                                              | d. STREET (If outside, give location) ADDRESS <u>5936 Cates Ave.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  |                                                                                                   |
| 3. NAME OF DECEASED (Type or print) <u>MR. ROBERT FARWELL WALTON</u> First Middle Last                                                                                                                                                                                                                                                                                                             |                                                                                              |                                                                                                                                                          | 4. DATE OF DEATH <u>July 22, 1956</u> Month Day Year                                              |
| 5. SEX <u>M.</u>                                                                                                                                                                                                                                                                                                                                                                                   | 6. COLOR OR RACE <u>W.</u>                                                                   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>April 30, 1875</u>                                                            |
| 9. AGE (In years last birthday) <u>81</u>                                                                                                                                                                                                                                                                                                                                                          |                                                                                              | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Sec'y Treas.</u>                                      | 11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri</u>                             |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Sec'y Treas.</u>                                                                                                                                                                                                                                                                               |                                                                                              | 10b. KIND OF BUSINESS OR INDUSTRY <u>St. Louis Express Co.</u>                                                                                           | 11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri</u>                             |
| 13. FATHER'S NAME <u>Farwell Walton</u>                                                                                                                                                                                                                                                                                                                                                            |                                                                                              | 14. MOTHER'S MAIDEN NAME <u>Dora Sommers / Margaret Mae Walton</u> name of wife                                                                          |                                                                                                   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>                                                                                                                                                                                                                                                                                |                                                                                              | 16. SOCIAL SECURITY NO. <u>499-26-1403</u>                                                                                                               |                                                                                                   |
| 17. INFORMANT <u>Robert McD. Walton</u>                                                                                                                                                                                                                                                                                                                                                            |                                                                                              | Address <u>5936 Cates Ave.</u>                                                                                                                           |                                                                                                   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Chronic Myocarditis &amp; ac. Myocarditis</u><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Acute Cholecystitis &amp; Empyema Gall Bladder</u><br>DUE TO (c) <u>Generalized Arteriosclerosis</u> |                                                                                              |                                                                                                                                                          | INTERVAL BETWEEN ONSET AND DEATH<br><u>5 days</u><br><u>2 weeks</u><br><u>years</u>               |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>Arterial Arteriosclerosis</u>                                                                                                                                                                                                                              |                                                                                              |                                                                                                                                                          | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>                                                                                                                                                                                                                                                                                          | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |                                                                                                                                                          |                                                                                                   |
| 20c. TIME OF INJURY<br>Hour Month, Day, Year<br>a. m. p. m.                                                                                                                                                                                                                                                                                                                                        | <u>422.1</u>                                                                                 |                                                                                                                                                          |                                                                                                   |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                             | 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)    | 20f. CITY, TOWN, OR LOCATION COUNTY STATE                                                                                                                |                                                                                                   |
| 21. I attended the deceased from <u>7-25-55</u> to <u>7-27-56</u> and last saw <u>him</u> alive on <u>July 21, 56</u><br>Death occurred at <u>6 PM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.                                                                                                                                                        |                                                                                              |                                                                                                                                                          |                                                                                                   |
| 22a. SIGNATURE (Degree or title)<br><u>James O. Kelly MD</u>                                                                                                                                                                                                                                                                                                                                       |                                                                                              | 22b. ADDRESS<br><u>79 1/2 Hildebrandt</u>                                                                                                                | 22c. DATE SIGNED<br><u>7-23-56</u>                                                                |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                                                                                                                                                                                                                                                                         | 23b. DATE<br><u>July 24, 1956</u>                                                            | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Bellefontaine Cem.</u>                                                                                          | 23d. LOCATION (City, town, or county) (State)<br><u>St. Louis Missouri</u>                        |
| 24. FUNERAL DIRECTOR ADDRESS<br><u>Alexander &amp; Sons, Inc. 6175 Delmar Blvd</u>                                                                                                                                                                                                                                                                                                                 |                                                                                              | 25. DATE RECD. BY LOCAL REG.<br><u>JUL 23 1956</u>                                                                                                       | 26. REGISTRAR'S SIGNATURE<br><u>Carl Smith MD</u><br><u>m&amp;b</u>                               |

Dr. Samuel D. Katz  
730 Hodiament Ave.

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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.....  
*Jos. E. McCulloch*

Licensed Embalmer No. *27*

P. O. Address... *4175*

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.