

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED SEP 17 1957

State File No. 34275

318

1003

Registrar's No. 6905

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. \_\_\_\_\_ PRIMARY REG. DIST. NO. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <b>St. Louis Mo.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MO.</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>27 HOMER G. PHILLIPS</b>		e. STREET ADDRESS (If rural, give location) <b>1110 4440 ST. FERDINAND</b>	
3. NAME OF DECEASED a. (First) <b>COLMAN</b>		b. (Middle) <b>WALTON</b>	c. (Last) <b>WALTON</b>
4. DATE OF DEATH (Month) (Day) (Year) <b>7-20-57</b>	5. SEX <b>M</b>	6. COLOR OR RACE <b>COL.</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>
8. DATE OF BIRTH <b>JAN. 15-1897</b>	9. AGE (In years last birthday) <b>60</b>	IF UNDER 1 YEAR <b>5</b> Days	IF UNDER 24 HRS. <b>5</b> Hours <b>Min.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>SELF EMPLOYER</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>MISSISSIPPI</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>WILLIAM WALTON</b>	13b. MOTHER'S MAIDEN NAME <b>KOSA MACKAY</b>	14. NAME OF HUSBAND OR WIFE <b>MARY WALTON</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>UNKNOWN</b>	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME <b>MARY WALTON</b> ADDRESS <b>4440 ST. FERDINAND</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) <b>Hypertension</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Chronic Nephritis</b> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>443 x</b>	
19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) _____	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____	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 <b>10:30 P.M.</b> , from the causes and on the date stated above.			
23a. SIGNATURE <b>[Signature]</b>		23b. ADDRESS <b>1300 Clair</b>	23c. DATE SIGNED <b>7/24/57</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	24b. DATE <b>7-26-57</b>	24c. NAME OF CEMETERY OR CREMATORY <b>OAKDALE</b>	24d. LOCATION (City, town, or county) (State) <b>COUNTY</b>
DATE REC'D BY LOCAL REG. <b>JUL 24 57</b>	REGISTRAR'S SIGNATURE <b>[Signature]</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>[Signature]</b> ADDRESS <b>1343 N. GARRISON</b>	

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

