

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

22561
Dr. Powell
File No. _____
Registered No. *543*
St. _____ Ward)

PLACE OF DEATH

County *St. Louis*
Township _____
City *Springfield* (No. *2001*)

Registration District No. *318*
Primary Registration District No. *2001*

2. FULL NAME

William C. Robertson

(a) Residence. No. *Republic Mo* St. _____ Ward. _____
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (For the word) *Single*

5A. IF MARRIED, WIDOWED, OR DIVORCED, HUSBAND OF (OR) WIFE OF *Single*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *June 23-1906*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
24 0 19

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work *Truck Driver*
(b) General nature of industry, business, or establishment in which employed (or employer) *Oiler*
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Republic Mo.*

10. NAME OF FATHER *Will Robertson*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER *Miss Russell*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) _____

14. INFORMANT (Address) *Alexander Robertson Republic Mo.*

15. FILED *7-14-30* *For Sharp* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *July 13th 1930*

17. I HEREBY CERTIFY, That I attended deceased from *July 5th 1930* to *July 12th 1930*, and that that I last saw him alive on *7-12-30*, and that death occurred, on the date stated above, at *9⁰⁰* a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

1 Typhoid Fever
about 10
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED *Missouri*
IF NOT AT PLACE OF DEATH, _____

9. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS
(Signed) *E. H. Marreiner*, M. D.
July 14, 1930 (Address) *Springfield Mo*

*State the DISEASE CAUSING DEATH, or in death from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL
Springfield Mo 7/14/30

20. UNDERTAKER ADDRESS
Thomas L. Sawyer Spz Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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