DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

JUL 17 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

21882

State File No.

Registration District No. 378 Primary Registration District No. 5528 Registrar's No. 47

1. PLACE OF DEATH:

(a) County Howard

(b) City or town Burton Township (Rural)
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location) 2

(d) Length of stay: In hospital or institution (Specify whether
In this community 1 year
years, months or days) 165

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Howard

(c) City or town Rural
(If outside city or town limits, write "RURAL")

(d) Street No. Armstrong, Mo. R.F.D. no 2
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME William Harvey Robertson

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Yes

6. (b) Name of husband or wife Mattie Alberta Robertson

6. (c) Age of husband or wife if alive 48 years

7. Birth date of deceased Sept. (Month) 26 (Day) 1888 (Year)

8. AGE: Years 51 Months 8 Days 26 If less than one day hr. min.

9. Birthplace Howard (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Farming

11. Industry or business 0

FATHER
12. Name Jefferson Childs Robertson
13. Birthplace Howard (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name Mary Eliza Bucker
15. Birthplace Chariton (City, town, or county) Missouri (State or foreign country)

16. (a) Informant's own signature Bertie R. Markland
(b) Address Armstrong, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June 24 1940 (Month) (Day) (Year)
(c) Place: burial or cremation Sharon Cemetery

18. (a) Signature of funeral director A H Oldaker
(b) Address Armstrong Mo

19. (a) July 8 1940 (Date received local registrar) (b) Mrs. D. O. Bonham (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 22nd year 1940 hour about 11 or 12 a.m. minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h — alive on , 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death Shot Gun wound of Head Accidental

Due to

Due to 184

Other conditions 17
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Accident
(b) Date of occurrence June 22 — 40
(c) Where did injury occur? At home Howard Mo (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? In yard of Home (Specify type of place)
While at work? — (e) Means of injury

23. Signature W R Hawkins (M. D. or other) 5
Address Georgetown Missouri Date signed

(Licensed Embalmer's Statement on Reverse Side)

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.

WHITE PERMANENT—USE UNFADING BLACK INK—PERMANENT RECORD

I X19511

RECEIVED
District Health Officer No. 8
Insurance File Number
Date Filed 7-15-48

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.....

.....Registered Apprentice No.....

working under my personal supervision.

Signed A. H. Oedaker

Licensed Embalmer No. 1667

P. O. Address Armstrong Mo

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, above space should be left blank.