

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **14843**BIRTH NO. _____ REG. DIST. NO. **38** PRIMARY REG. DIST. NO. **3006** Registrar's No. **139**

1. PLACE OF DEATH a. COUNTY Boone Co		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Howard	
b. CITY (If outside corporate limits, write RURAL and give town) Columbia		c. CITY (If outside corporate limits, write RURAL and give township) Roanoke	
c. LENGTH OF STAY (If in this place) 3 days		d. STREET ADDRESS (If rural, give location) 1	
d. FULL NAME OF HOSPITAL OR INSTITUTION Noyes Hospital			
3. NAME OF DECEASED a. (First) William b. (Middle) - c. (Last) Robertson		4. DATE OF DEATH (Month) (Day) (Year) 6 2 1949	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Sept 11 1872
9. AGE (In years last birthday) 76		IF UNDER 1 YEAR Months 8 Days 21	IF UNDER 48 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School teacher Education		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Mo
12. CITIZEN OF WHAT COUNTRY? USA			
13a. FATHER'S NAME Andrew Jackson Robertson		13b. MOTHER'S MAIDEN NAME Caroline Davis	14. NAME OF HUSBAND OR WIFE Helen Robertson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no	17. INFORMANT'S SIGNATURE OR NAME Lawrence Robertson
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Embolism (post operative) ANTECEDENT CAUSES DUE TO (b) thrombosis - upper & lower veins DUE TO (c) Infection - 2 ft shoulder joint II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis -	
19a. DATE OF OPERATION June 2, 1949		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)			
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 May 31, 1949 , to June 2, 1949 , that I last saw the deceased alive on June 2, 1949 , and that death occurred at 5: P m., from the causes and on the date stated above.			
23a. SIGNATURE Walter Bivins		(Degree or title) MO University Hospital, Columbia Mo	
23b. ADDRESS Mo		23c. DATE SIGNED June 3, 1949	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 6-5-1949	
24c. NAME OF CEMETERY OR CREMATORY Roanoke		24d. LOCATION (City, town, or county) (State) Roanoke Mo	
DATE REC'D BY LOCAL REG. June 3 1949		REGISTRAR'S SIGNATURE Mrs. R. E. Palmer	
25. FUNERAL DIRECTOR'S SIGNATURE Geo. Blum		ADDRESS Roanoke	

(Licensed Embalmer's Statement on Reverse Side)

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

10
2
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RECEIVED
District Health Officer No. 9,
District File Number
Date Filed JUN 9 1949

JAN 19 1950

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.

Signed
Student Embalmer

Signed *Chas B Winkelmeyer*

Licensed Embalmer No. *3842*

P. O. Address *Salisbury Md*

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, fact should be so stated above.