

STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 146 PRIMARY REG. DIST. NO. 3026 Registrar's No. 417

1. PLACE OF DEATH  
 a. COUNTY Jackson  
 b. CITY OR TOWN Independence  
 c. LENGTH OF STAY (in this place)  
 d. FULL NAME OF HOSPITAL OR INSTITUTION Sanitarium & Hospital

2. USUAL RESIDENCE (Where deceased lived) If institution: residence before admission)  
 a. STATE Mo b. COUNTY Jackson  
 c. CITY OR TOWN Oak Grove d. ZIP CODE 6460  
 d. STREET ADDRESS 1

3. NAME OF DECEASED  
 a. (First) William b. (Middle) W. c. (Last) Robertson

4. DATE OF DEATH (Month) (Day) (Year)  
Nov-10-1951

5. SEX M 6. COLOR OR RACE W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)  
Married

8. DATE OF BIRTH Mar-4-1865

9. AGE (In years last birthday) 86  
 # UNDER 1 YEAR Months Days # UNDER 15 MINS. Hours Mins.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
Retired

10b. KIND OF BUSINESS OR INDUSTRY  
Farmer

11. BIRTHPLACE (State or foreign country)  
Boonville Mo

12. CITIZEN OF WHAT COUNTRY?  
USA

13a. FATHER'S NAME  
Charles Robertson

13b. MOTHER'S MAIDEN NAME  
Elizabeth Henry

14. NAME OF HUSBAND OR WIFE  
Grace Robertson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S SIGNATURE OR NAME ADDRESS  
Grace Robertson Oak Grove Mo

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) Toxemia  
 ANTECEDENT CAUSES  
 Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  
 DUE TO (b) Reflex ileus  
 DUE TO (c) Trauma associated with fractured hip  
 II. OTHER SIGNIFICANT CONDITIONS  
 Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION  
048

20. AUTOPSY? YES  NO

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)

21e. INJURY OCCURRED WHILE AT WORK  NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Pathologist, 1951, that I last saw the deceased alive on 11-10-51, and that death occurred at 11-10-51, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)  
Lorraine E. Schultz M.D.

23b. ADDRESS  
Independence San. & Hospital

23c. DATE SIGNED  
11-10-51

24a. BURIAL, CREMATION, REMOVAL (Specify)  
Burial

24b. DATE  
Nov 12 1951

24c. NAME OF CEMETERY OR CREMATORY  
Oak Grove

24d. LOCATION (City, town, or county) (State)  
Oak Grove Mo

DATE REC'D BY LOCAL REG.  
Nov. 12-1951

REGISTRAR'S SIGNATURE  
[Signature]

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS  
[Signature] Webb Funeral Home - Oak Grove Mo

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

#485  
0

NOV 27 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.....

.....  
working under my personal supervision.

Student Embalmer No.....

Signed.....

*R B Webb*

Signed.....  
Student Embalmer

Licensed Embalmer No. 2313

P. O. Address Blue Springs 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, fact should be so stated above.