

FILED JUL 12 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **19135**
2790

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. CITY OR TOWN Kansas City	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (In this place) 3 1/2 Yrs.		e. STREET ADDRESS (If rural, give location) 1235 Campbell	
d. FULL NAME OF HOSPITAL OR INSTITUTION General Hospital		14 3148 2	
3. NAME OF DECEASED (Type or Print) a. (First) PAUL	b. (Middle) GEORGE	c. (Last) ROBERTSON	4. DATE OF DEATH (Month) (Day) (Year) June 20, 1954
5. SEX D Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH April 12, 1919
9. AGE (In years last birthday) 35		# UNDER 1 YEAR Months	# UNDER 2 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder		10b. KIND OF BUSINESS OR INDUSTRY Metal Craft Mfg. Vending Machines	11. BIRTHPLACE (City and State or Foreign Country) Porum, Oklahoma
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13a. FATHER'S NAME Walter L. Robertson	
13b. MOTHER'S MAIDEN NAME Lula Jackson		14. NAME OF HUSBAND OR WIFE Aline A. Robertson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 447-18-8895	17. INFORMANT'S SIGNATURE OR NAME Mrs. Aline A. Robertson ADDRESS K. C. Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* Chronic Granulomatous		INTERVAL BETWEEN ONSET AND DEATH	
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (a) Reaction involving brain cells	
ANTECEDENT CAUSES		DUE TO (b) Langhain Lateral Neutrocytes	
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (c) Cerebral Cortex & areas of Encephalomyelitis	
II. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION 1-7-8-54	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE 1 (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) m.	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 at _____ m., from the causes and on the date stated above.			
23a. SIGNATURE Hugh H. Owens (Degree or title) 3		23b. ADDRESS 1034 Rialto Bldg	23c. DATE SIGNED 6-21-54
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 6-23-54	24c. NAME OF CEMETERY OR CREMATORY Green Lawn	24d. LOCATION (City, town, or county) (State) Kansas City, Mo.
DATE REC'D BY LOCAL REG. 6-21-54	REGISTRAR'S SIGNATURE Steldine Smith	25. FUNERAL DIRECTOR'S SIGNATURE Freeman Mortuary	ADDRESS Kansas City, Mo.

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10-48

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, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed..... *Walter H. Erwin*

Licensed Embalmer No. *435*

P. O. Address *Kansas City*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.