

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JAN 13 1958

46255

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **12578**

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		Length of stay in 1b	d. STREET ADDRESS 5226 Washington Blvd.
3. NAME OF DECEASED (Type or print) First CHARLES Middle WILLIAM Last ROBERTSON		4. DATE OF DEATH DECEMBER 25, 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 9, 1889
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 68
11. BIRTHPLACE (City and state or country) PERRY CO. MO.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Francis E. Robertson		13b. MOTHER'S MAIDEN NAME Bonnie Belle Voelker	14. NAME OF HUSBAND OR WIFE Anna 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. 489-28-5949	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA		INTERVAL BETWEEN ONSET AND DEATH 2 DAYS	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) EPIDERMOID CARCINOMA OF LARYNX		6 MONTHS	
DUE TO (c)		161x	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from DEC. 14, 1957 to DEC. 25, 1957 and last saw ^{her} him alive on DEC. 25, 1957 Death occurred at 5:45 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>C. Q. Vermillion, M. D.</i> (Degree or title) M. D.		22b. ADDRESS BARNES HOSPITAL	
22c. DATE SIGNED 12/26/57			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-28-57	23c. NAME OF CEMETERY OR CREMATORY Methodist
23d. LOCATION (City, town, or county) Festus., Mo.		(State)	
24. FUNERAL DIRECTOR Vinyard Funeral Home, Inc. Festus, Mo.		25. DATE RECD. BY LOCAL REG. DEC 30 57	26. REGISTRAR'S SIGNATURE <i>J. Earl Smith, M.D.</i> Mig. B.

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 *Donald H. Wingard*

Licensed Embalmer No. *4608*

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