

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-040770

STATE OF MISSOURI DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Dr. **Clayson**

Registration District No. **128**

Primary Registration District No. **300**

Registrar's No. **1187**

STATE FILE NUMBER

AMENDED

FILED DEC 11 1961

DATE AMENDED

INSTEAD OF

DOCUMENT

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) MISSOURI b. COUNTY POLK	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD		Length of stay in lb 1 MO.	c. CITY OR TOWN WALNUT GROVE
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. JOHN'S HOSP.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) RT # 3 BOX # 1538
3. NAME OF DECEASED (Type or print) CHARLES W. ROBERTSON		First Middle Last	4. DATE OF DEATH Month DEC. Day 1 Year 1961

5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1/24/05	9. AGE (last birthday) 56	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) WALNUT GROVE, MO.		12. CITIZEN OF WHAT COUNTRY USA	

13a. FATHER'S NAME WILLIAM J. ROBERTSON	13b. MOTHER'S MAIDEN NAME MARY ANN SUMMEVILLE	14. NAME OF HUSBAND OR WIFE LUCY ROBERTSON
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service.) NO		17. INFORMANT Address MRS. LUCY ROBERTSON, WALNUT GROVE MO.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) *Massive hemorrhage from entire G-D tract - diagnosed - cause unknown*

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) *Had vegetative & hemiparesis*

DUE TO (c) *on 10 Nov 61. Replaced on 30 Nov 61*

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) *no bleeding point found. no placental, etc. found at autopsy. had severe cerebral war*

PART III. If deceased was female was there a pregnancy in last 90 days.
 Yes No Unknown

INTERVAL BETWEEN ONSET AND DEATH **5 days.**

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 Month, Day, Year p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT 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 **Nov 9, 1961**, to **Dec 1, 1961** and last saw ^{her}him alive on **Nov 30, 1961**
Death occurred at **4:35 A.M.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) J.W. Clayson, M.D.	22b. ADDRESS Springfield, MO	22c. DATE SIGNED 1 Dec 61
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 12/4/61	23c. NAME OF CEMETERY OR CREMATORY HAZELWOOD
23d. LOCATION (City, town, or county) SPRINGFIELD, MO.		(State)

24. FUNERAL DIRECTOR ADDRESS H.H. LOHMEYER FUNERAL HOME SPRINGFIELD, MO.	25. DATE RECD. BY LOCAL REG. 12-4-61	26. REGISTRAR'S SIGNATURE Effie S. Melton
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ITEM NO. SHOULD READ

BY AFFIDAVIT OF

