

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **879**
19

FILED JAN 14 1952
BIRTH NO. **120464-51** REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **2000** Registrar's No. **19**

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

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Greene	
b. CITY OR TOWN Springfield		c. CITY OR TOWN Springfield	
c. LENGTH OF STAY (In this place) 9 days		d. STREET ADDRESS (If rural, give location) Route 4, Springfield	
d. FULL NAME OF HOSPITAL OR INSTITUTION Burge Hospital			

3. NAME OF DECEASED (Type or Print)	a. (First) ROBERT	b. (Middle) WAYNE	c. (Last) CAMERON	4. DATE OF DEATH (Month) (Day) (Year) January 7 1952
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married	8. DATE OF BIRTH Sept 13, 1951	9. AGE (In years last birthday) 3 Months 24 Days	IF UNDER 18 HRS. 0 Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child	10b. KIND OF BUSINESS OR INDUSTRY Child	11. BIRTHPLACE (State or foreign country) Springfield, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME James Lee Cameron	13b. MOTHER'S MAIDEN NAME Mildred Pearl Lindell	14. NAME OF HUSBAND OR WIFE ---
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	(If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Minnie Landsdown, Springfield, Mo.	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH from birth
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hydrocephalus		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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
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22. I hereby certify that I attended the deceased from **12-28-1951**, to **1-7-1952**, that I last saw the deceased alive on **1-7-1952**, and that death occurred at **11** a. m., from the causes and on the date stated above.

23a. SIGNATURE James H. Amos, M.D.	(Degree or title)	23b. ADDRESS Springfield, Mo.	23c. DATE SIGNED 1-10-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Jan 10, 1952	24c. NAME OF CEMETERY OR CREMATORY Eastlawn Cemetery	24d. LOCATION (City, town, or county) (State) Springfield, Missouri
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DATE REC'D BY LOCAL REG. 1-10-52	REGISTRAR'S SIGNATURE James H. Amos, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Alma Schreyer, Springfield, Mo.	ADDRESS
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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 Bernard F Wright

Signed.....
Student Embalmer

Licensed Embalmer No. 4293

P. O. Address Springfield, 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.