

STANDARD CERTIFICATE OF DEATH  
DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

ARIZONA STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL STATISTICS

State File No. 87V

Registrar's No. 49

1. Place of Death: (a) County Gila (b) City or Town Miami (c) Location M. J. Hospital  
(If outside city limits also write RURAL) (St. & No. (or) Name of Institution)

(d) Length of Stay: In Hospital or Institution 3 days; In Community 3 days; in Arizona 3 days  
(Specify whether years, months or days)

2. Usual Residence of Deceased: (a) State Ariz.; (b) County Gila; (c) City or Town Globe  
(If outside city limits also write RURAL)

(d) Street No. 107 Central Ave. Central Heights; (e) Citizen of foreign country (yes or No) No  
If Yes, which country \_\_\_\_\_ (f) Social Security No. none

3. (a) FULL NAME William Loney Robertson (b) If Veteran name war \_\_\_\_\_ (c) Social Security No. none

4. Sex <u>Male</u>	5. Color or Race <u>White</u>	6. (a) Single, married, widowed or divorced <u>Infant</u>
6. (b) Name of husband or wife _____		6. (c) Age of husband or wife, if alive _____ yrs.
7. Birthdate of deceased <u>July 27 1943</u> (Month) (Day) (Year)		
9. AGE: Years Months Days If less than one day <u>0 0 3</u> hrs. _____ min. _____		
9. Birthplace <u>Miami Ariz.</u> (City, town or county) (State or Country)		

10. Usual Occupation \_\_\_\_\_

11. Industry or Business \_\_\_\_\_

Father { 12. Name Lerie Boyd Robertson  
13. Birthplace Mataca Texas  
(City, town or county) (State or Country)

Mother { 14. Maiden Name Agnes Brown  
15. Birthplace Ladson Texas  
(City, town or county) (State or Country)

16. (a) Informant's own signature William Loney Robertson  
(b) Address Globe Ariz. Rt. 1, Box 122

17. (a) Burial, Cremation or Removal Burial  
(b) Place Pinal Cem. (c) Date July 31 1945

18. (a) Embalmer's Signature Gerald W. Lawrence  
(b) Funeral Director Miles Mortuary  
(c) Address Miami Ariz.

19. (a) Aug 30 1945  
(Date received local Registry)

(b) Allen A. Brayton  
(Registrar's Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH (Month, day and year) July 30 1945  
TIME (Hour and minute) about 14:00 A.M.

21. I hereby certify that I attended the deceased from 7-27 1945 to 7-30 1945  
that I last saw him alive on 7-30 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Atelactasia

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

DURATION

3 days

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or Town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_ (Specify type of place)

While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature M. E. Burgess M. D.  
Address Miami Ariz. Date signed 8-1-45