

FILED JUN 12 1943

Registration District No. _____

Primary Registration District No. 3000

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

1. PLACE OF DEATH:

(a) County Adair
(b) City or town Keokuk
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 250. Hosp. O
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 days
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME DALE SPENCER ROBINSON

3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex male 5. Color or race Y
6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased April 15 1942
(Month) (Day) (Year)

8. AGE: Years _____ Months 5 Days _____
If less than one day _____ hr. _____ min.

9. Birthplace Keokuk Mo. O
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name Lynn E. Robinson

13. Birthplace Keokuk Mo. O
(City, town, or county) (State or foreign country)

14. Maiden name Robinson

15. Birthplace Keokuk Mo. O
(City, town, or county) (State or foreign country)

16. (a) Informant Taylor Lynn Robinson

(b) Address Keokuk Mo.

17. (a) burial (b) Date thereof 4/20/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Keokuk Mo.

18. (a) Signature of funeral director Lynn Robinson

(b) Address Keokuk Mo. (Father)

19. (a) 4/20/43 (b) Mrs. J. Wayne
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Shelby
(c) City or town Keokuk
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 20
year 1943 hour 7 minute 55 A.M.

21. I hereby certify that I attended the deceased from Apr. 15
19 Apr. 20 19 43
that I last saw alive on Apr. 20 19 43
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Palsy -
Prolonged Labor

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death) 160c

Major findings: Of operations _____

Of autopsy _____

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature J. H. Dwyer (M.D. or other) _____

Address Keokuk Mo. Date signed 4/20/43

RECEIVED

District Health Officer No. 10

District File Number 6-43-1079

Date Filed JUN 11 1943

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.