S. No. 2
M—1/47
. 5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED AUG 26 1947

Registration District No. 149

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 27911

Registrar's No. 3467

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Children's Mercy Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 48 hrs., 10 min. (Specify whether In this community years, months or days) 1 month

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City (If outside city or town limits, write "RURAL") 3

(d) Street No. 3400 Norledge (If rural give location) 8

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Dennis Gerald Robinson

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex M. O

5. Color or race W

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 3 (Month) 3 (Day) 1947 (Year)

8. AGE: Years | Months 5 | Days ~~8~~ 9 | If less than one day hr. min.

9. Birthplace Blue Bemidji, Minnesota (City, town, or county) (State or foreign country)

10. Usual occupation Baby

11. Industry or business

FATHER
12. Name Ralph Junior Robinson
13. Birthplace Des Moines, Iowa (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Dolores Carolyn Martin
15. Birthplace Brainard, Minnesota (City, town, or county) (State or foreign country)

16. (a) Informant Father

(b) Address 3400 Norledge, K.C., Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Aug 13-47 (Month) (Day) (Year)

(c) Place: burial or cremation Laport Minnesota

18. (a) Signature of funeral director Wm C L Foster

(b) Address 918 Brooklyn

19. (a) 8-12-47 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 12 year 1947 hour 12 minute 50 a. M.

21. I hereby certify that I attended the deceased from 8-10, 1947 to 8-12, 1947 that I last saw h alive on , 19 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Intestinal obstruction, Acute	
Due to ileo-cecal intussusception	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings: Of operations as above 12-26

Of autopsy —

PHYSICIAN

Underline the cause of 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 Dr. E Schmidt per Jm Kantor M.D. (M. D. or other)

Address Mercy Hospital Date signed Aug 12/47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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.