

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

36220
2026

1. PLACE OF DEATH
 County Jackson Registration District No. 300
 Township Kaw Primary Registration District No. 1000
 City Kansas City (No. 4010 Roanoke Road St. _____ Ward _____)

2. FULL NAME Robert Kenneth Dando
 (a) Residence. No. 4010 Roanoke Road St. 7 Ward _____
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Child

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF --

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar. 11, 1929

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	1	8	3	

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Child
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Kansas City,
 (STATE OR COUNTRY) Mo.

10. NAME OF FATHER Kenneth I Dando

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Kansas City,
 (STATE OR COUNTRY) Mo.

12. MAIDEN NAME OF MOTHER Virginia Hunohman

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) Kansas

14. INFORMANT Baback
Kenneth I. Dando
 (Address) 4010 Roanoke Road

15. FILED 11-15-30 M M Brown REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 14, 1930¹⁹

17. I HEREBY CERTIFY, That I attended deceased from Nov 30 to Nov 14 1930
 that I last saw him alive on Nov 14 1930, and that death occurred, on the date stated above, at 2:30 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Bacterial Pneumonia

107A (duration) yrs. mos. 8 ds.

CONTRIBUTORY (SECONDARY) _____ (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS clinical
 (Signed) M. Haynes M. D.

11-15-30 (Address) 707 Westport Ave

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Mt. Moriah DATE OF BURIAL 11-17-30¹⁹

20. UNDERTAKER R.V. Lindsey & Sons, Inc. ADDRESS City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

