

FEDERAL BUREAU OF INVESTIGATION  
STANDARD CERTIFICATE OF DEATH

26446

State File No. \_\_\_\_\_

FILED AUG 26 1948

Registration District No. 119

Primary Registration District No. 1002

Registrar's No. 3224

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

**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:  
Osteopathic Hospital  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 10 minutes  
(Specify whether years, months or days)  
 In this community 10 minutes  
(Specify whether years, months or days)

**3: (a) PRINT FULL NAME** ROBBIE S LYNCH

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Infant

6. (b) Name of husband or wife X 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased June 15 1948  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months 1 Days 22 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Marshall, Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Infant

11. Industry or business X

12. Name Robert L. Lynch

13. Birthplace Marshall, Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Dorothy Johnson

15. Birthplace Slater, Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Robert Lynch

(b) Address Marshall, Missouri

17. (a) Burial (b) Date thereof Aug 9, 1948  
(Burial, cremation, or removal) (Month) (Day) (Year)

(a) Place: burial or cremation Marshall, Missouri

18. (a) Signature of funeral director Wilks Funeral Home

(b) Address 2315 Linwood K. C., 3 Mo

19. (a) 8-8-48 (b) Sheraldine Holmes  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Missouri (b) County Saline 97  
 (c) City or town Marshall  
(If outside city or town limits, write "RURAL") 1  
 (d) Street No. X  
(If rural, give location) 2  
 (e) Citizen of foreign country? No (Yes or No) 1  
 If yes, name country \_\_\_\_\_ X

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Aug day 7  
 year 1948 hour 7 minute P M.

21. I hereby certify that I attended the deceased from Brown, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
 that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.

Immediate cause of death Premature birth 18 minutes  
 Duration \_\_\_\_\_

Due to Malnutrition

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

Other conditions  
(Include pregnancy within 3 months of death)

Major findings:  
 Of operations 159

Of autopsy History & Inspection

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 [Signature] (M. D. or other) \_\_\_\_\_  
 Address [Address] Date signed [Date]

**PHYSICIAN**  
 \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

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

Signed Chas E Wilks

Licensed Embalmer No 2644

P. O. Address K.C. 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.**