

S. No. 2  
-11-17  
5-17  
MI X21

Registration District No. **399**

Primary Registration District No. **1002**

Registrar's No.

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:  
St. Luke's Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 11/13 Months 26 Days  
(Specify whether  
In this community 64 Years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
Street No. 40 West 70th Street  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.?

3. (a) PRINT FULL NAME Mr. Arthur Hubbard Kendall

3. (b) If veteran, name war None 3. (c) Social Security No. 708-18-8451

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

6. (b) Name of husband or wife Mrs. Dorothy B. Kendall 6. (c) Age of husband or wife if alive 15 years (Day) (Year)

7. Birth date of deceased June 15 1874  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
66 6 3 hr. min.

9. Birthplace Lawrence Kansas  
(City, town, or county) (State or foreign country)

10. Usual occupation Pullman Conductor

11. Industry or business S

12. Name Hubert Kendall

18. Birthplace Connecticut  
(City, town, or county) (State or foreign country)

14. Maiden name Mary

15. Birthplace

16. (a) Informant

(b) Address

17. (a) Burial (b) Date thereof 11/13  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Moriah Cemetery

18. (a) Signature of funeral director O. H. Newcomer's Son

(b) Address 1401 Brush Creek Blvd.

19. (a) 12-20-40 (b) M. B. Crowe  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 18th  
year 1940 hour Noon minute M.

21. I hereby certify that I attended the deceased from not  
1 1934 to Dec 18 1940  
that I last saw him alive on Dec 18 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Subacute bacterial endocarditis - Rheumatic etiology  
Due to hypertension  
Chronic pyelonephritis  
Site of Patent ductus arteriosus  
Other conditions 137  
(Include pregnancy within 3 months of death)

Major findings: Prosthetic hypertrophy  
Of operations Thoracic aortic aneurysm  
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 1

23. Signature W. H. G. G. G. G. M. D. or (State)  
Address 2707 S. Main St. Date signed 12/21/40

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

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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 Emile M. Calhoun

Licensed Embalmer No. 3506

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, above space should be left blank.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 41442  
Registrar's No. 4835

Registration District No. 399

Primary Registration District No. 1002

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

PLACE OF DEATH:

(a) County Jackson  
(b) City or town St. C.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME Arthur Hubbard Kendall  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
66 6 3 hr. min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

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

14. Maiden name Mary Fitzgerald

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

16. (a) Informant Mrs Dorothy Kendall

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 1/20/41 (b) M. M. Crowe  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (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 Dec day 18  
year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

Duration \_\_\_\_\_

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

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

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

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

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

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? \_\_\_\_\_

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

23. Signature Robert MacLachlan (M. D. or other) \_\_\_\_\_

Address 832 Pratt Bldg. Date signed \_\_\_\_\_

SUPPLEMENTARY

S-41442 1940