

FILED SEP 7 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **27358**  
**3940**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 3940

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>KANSAS CITY</b>		c. LENGTH OF STAY (in this place) <b>LIFE</b>	c. CITY OR TOWN <b>KANSAS CITY</b>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. LUKES HOSPITAL</b>		f. STREET ADDRESS (If rural, give location) <b>714 5636 MONTGALL AVENUE</b>	

3. NAME OF DECEASED (Type or Print) <b>ARTHUR J HENDRICKSON</b>			4. DATE OF DEATH <b>AUGUST 11, 1954</b>		
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MECHANIC</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>COOLING TOWERS DUSTY MARLEY COMPANY</b>		8. DATE OF BIRTH <b>OCT. 25, 1893</b>	
11. BIRTHPLACE (City and State or Foreign Country) <b>KANSAS CITY, MISSOURI</b>		9. AGE (In years last birthday) <b>60</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>AUGUST HENDRICKSON</b>			
13b. MOTHER'S MAIDEN NAME <b>MARY MATILDA ANDERSON</b>		14. NAME OF HUSBAND OR WIFE <b>MATTIE HENDRICKSON</b>			

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>486-01-5352</b>		17. INFORMANT'S SIGNATURE OR NAME <b>MRS. MATTIE HENDERSON</b>	
(If yes, give war or dates of service) <b>WORLD WAR I</b>				ADDRESS <b>5636 MONTGALL, MO. K.C.</b>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Pulmonary embolism.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>~ minutes</b>	
		ANTECEDENT CAUSES DUE TO (b) <b>Carcinoma prostate &amp; metastases 2 yrs</b> DUE TO (c) <b>Chronic venous insufficiency w/ly 6 mos. due to old thrombophlebitis</b>			
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		177X	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 1953, 19  , to Aug 11, 1954, that I last saw the deceased alive on Aug 10, 1954 and that death occurred at 7:08 AM, from the causes and on the date stated above.

23a. SIGNATURE (Ink or blue ink) <b>Dr. W. Robinson</b>		23b. ADDRESS <b>4635 WYANDOTTE, K.C. MO.</b>		23c. DATE SIGNED <b>8-11-1954</b>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24b. DATE <b>AUG. 14 1954</b>		24c. NAME OF CEMETERY OR CREMATORY <b>MT. MORIAN CEMETERY</b>	
24d. LOCATION (City, town, or county) (State) <b>KANSAS CITY MISSOURI</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>W. H. Newnam</b>		ADDRESS <b>1331 BRUSH GREEK KANSAS CITY, MISSOURI</b>	

DATE REC'D BY LOCAL REG. **8-14-54** REGISTRAR'S SIGNATURE **Rosalind Smith**

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD  
A. W. Robinson M.D.

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 ....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed..... Basil V. Hoine

Licensed Embalmer No. 47

P. O. Address R.C.

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.