

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-021517

FILED JUN 17 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2689

300  
-57

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, give TOWNSHIP only) <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kansas City</b> 518
c. FULL NAME OF (IF NOT in hospital, give location) <b>St. Josephs Hosp.</b>		Length of stay in lb <b>39 yrs.</b>	d. STREET ADDRESS <b>3811 Askew St.</b>

3. NAME OF DECEASED (Type or print) First <b>Ida</b> Middle <b>Nell</b> Last <b>McArthur</b>			4. DATE OF DEATH Month <b>May</b> Day <b>31</b> Year <b>1959</b>		
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG 8 1896</b>	9. AGE (In years last birthday) <b>63</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>GREENWOOD, MO</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>ALEXANDER THEODORE KENNEDY</b>	13b. MOTHER'S MAIDEN NAME <b>JOEANN OLINGER</b>	14. NAME OF HUSBAND OR WIFE <b>JAMES MCARTHUR</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>	16. SOCIAL SECURITY NO. <b>447 05 9534</b>	17. INFORMANT Address <b>DOROTHY MCARTHUR 2230 DENVER</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b>		INTERVAL BETWEEN ONSET AND DEATH <b>60 hrs</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Coronary atherosclerosis</b>	<b>18 months</b>
	DUE TO (c) <b>Arteriosclerosis, generalized</b>	<b>6 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Rheumatoid arthritis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from <b>Feb 8 1952</b> to <b>5-31-59</b> and last saw her alive on <b>5-30-59</b> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE (Degree or title) <b>Charles I. Cooper M.D.</b>	22b. ADDRESS <b>1226 Riata Bldg KC, Mo</b>	22c. DATE SIGNED <b>6-1-59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>JUNE 2, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>PLEASANT HILL CEM</b>	23d. LOCATION (City, town, or county) (State) <b>PLEASANT HILL MO.</b>
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24. FUNERAL DIRECTOR ADDRESS <b>D. W. Newcomers Sons Kansas City, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>6-1-59</b>	26. REGISTRAR'S SIGNATURE <b>Ilva Minshall</b>
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All diseases in Part I must be causally related.  
Charles I. Cooper  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Thomas W. Larson* .....

Licensed Embalmer No. *4889*.....

P. O. Address *D.C., N.O.*.....

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.