

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-025023

FILED VS AUG 10 1959/49

Primary Registration District No. 1002

Registrar's No. 3604

STATE FILE NUMBER

DED

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Jackson</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u> Length of stay in 1b <u>43 Yrs.</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Menorah Medical Center</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u> c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>3912 Wabash</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Phillip</u> Middle <u>Bucksner</u> Last <u>Bucksner</u>			<b>4. DATE OF DEATH</b> Month <u>7</u> Day <u>25</u> Year <u>59</u>				
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Approx. 75</u>	<b>9. AGE (last birthday)</b> <u>75</u>	IF UNDER 1 YEAR Months Days Hours Min.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired Merchant</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Vegetable</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>Poland</u>			
<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A.</u>		<b>13a. FATHER'S NAME</b> <u>Abraham Bucksner</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>Chapora</u>			
<b>14. NAME OF HUSBAND OR WIFE</b> <u>Anna Bucksner</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>unknown</u>			
<b>17. INFORMANT</b> <u>Anna Bucksner 3912 Wabash</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Carcinoma of Lung (Bronchogenic)</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____			
<b>20f. CITY, TOWN, OR LOCATION</b> _____		<b>COUNTY</b> _____		<b>STATE</b> _____			
<b>21. I attended the deceased from</b> <u>1947</u> to <u>7/25/59</u> and last saw <sup>her</sup> him alive on <u>7/24/59</u> Death occurred at <u>5 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> <u>John W. Wolf</u> (Degree or title)		<b>22b. ADDRESS</b> <u>409 E. 63 St. Kansas City, Mo.</u>		<b>22c. DATE SIGNED</b> <u>7/25/59</u> (State)			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE</b> <u>7/26/59</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Blue Ridge Cemetery</u>			
<b>23d. LOCATION</b> (City, town, or county) <u>Kansas City, Missouri</u>		<b>25. DATE RECD. BY LOCAL REG.</b> <u>7-25-59</u>					
<b>24. FUNERAL DIRECTOR</b> <u>J.P. Louis Funeral Home. K.C. Mo.</u>		<b>26. REGISTRAR'S SIGNATURE</b> <u>Deva Minichell</u>					

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

John W. Wolf

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed *Greg Buffington.*

Licensed Embalmer No. 2756

P. O. Address KC M

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.