RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

59-032252

STATE FILE NUMBER

FILED OCT 13 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4685

1. PLACE OF DEATH
a. COUNTY JACKSON
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY — Length of stay in 1b: 52yrs.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 6650 WOODLAND — Inside Limits Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MISSOURI b. COUNTY JACKSON
c. CITY OR TOWN KANSAS CITY — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location) 6650 WOODLAND — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First (Nell) Middle PENELOPE Last LORAINE BUEHNER
4. DATE OF DEATH Month SEPT Day 20 Year 1959
5. SEX FEMALE
6. COLOR OR RACE WHITE
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH NOV 30, 1890
9. AGE (last birthday) 69 yrs. — IF UNDER 1 YEAR Months Days — IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) HARDIN MISSOURI
12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME SAMUEL S. MARRS
13b. MOTHER'S MAIDEN NAME ARABELLE LAME
14. NAME OF HUSBAND OR WIFE LAWRENCE P. BUEHNER
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 495 05 1099
17. INFORMANT LAWRENCE P. BUEHNER Address 6650 WOODLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Addisons Disease — INTERVAL BETWEEN ONSET AND DEATH 2 yrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Resulting Asthenia or Myocardial failure
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. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 2-5-59, to 9-27-59 and last saw her alive on 9-27-59
Death occurred at 10:40 A.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Geo. H. Jones M.D. (Degree or title)
22b. ADDRESS 1435 E 78th St. Kansas City Mo.
22c. DATE SIGNED 9-27-59

BY AFFIDAVIT OF Geo. H. Jones

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE SEPT 29 1959
23c. NAME OF CEMETERY OR CREMATORY MT. MORIAH CEM
23d. LOCATION (City, town, or county) (State) KANSAS CITY MO
24. FUNERAL DIRECTOR ADDRESS GD. W. NEWCOMER'S SONS K. C. MO.
25. DATE RECD. BY LOCAL REG. 9-28-59
26. REGISTRAR'S SIGNATURE Freva Minshall

(Licensed Embalmer's Statement on Reverse Side)

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_____ Signed Roger L. Fuller

Signature of Student Embalmer

Licensed Embalmer No. 4818

P. O. Address KC Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co 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.