

**MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-015192**

FILED VS MAY 5 1960

149

Registration District No. \_\_\_\_\_ Primary Registration District No. 1002 Registrar's No. \_\_\_\_\_

**2083**

STATE FILE NUMBER

UNDECEASED

|  |  |   |   |  |  |   |  |
|--|--|---|---|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Jackson</u>  |  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Kansas</u> b. COUNTY <u>Johnson</u>                               |  |   |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br><u>Kansas City</u>  |  | Length of stay in 1b<br><u>6 months</u>   |   | c. CITY OR TOWN <u>Kansas City</u>   |  | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                            |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>Kelly Nursing Home</u>   |  |   |   | d. STREET ADDRESS (If outside, give location)<br><u>4900 Clark Drive</u>   |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                           |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Mary</u> Middle <u>Jane</u> Last <u>Buynne</u>   |  |   | 4. DATE OF DEATH<br>Month <u>4</u> Day <u>11</u> Year <u>1960</u> |  |  |   |  |
| 5. SEX <u>Female</u>   |  | 6. COLOR OR RACE <u>White</u>   |   | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>Sept. 8-1894</u>  |  |
| 9. AGE (last birthday) <u>65</u>   |  | IF UNDER 1 YEAR<br>Months _____ Days _____  |   | IF UNDER 24 HR<br>Hours _____ Min. _____   |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u> |  |
| 10b. KIND OF BUSINESS OR INDUSTRY<br><u>at home</u>  |  | 11. BIRTHPLACE (City and state or county)<br><u>Austria</u>   |   | 12. CITIZEN OF WHAT COUNTRY<br><u>U.S.A</u>  |  |   |  |
| 13a. FATHER'S NAME<br><u>Frank Kubovic</u>   |  |   | 13b. MOTHER'S MAIDEN NAME<br><u>Unknown</u>                       |  |  | 14. NAME OF HUSBAND OR WIFE<br><u>Andrew M Buynne</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u>   |  | 16. SOCIAL SECURITY NO.<br><u>514-22-1434</u>   |   | 17. MRS. <u>Julia Turner</u> Address <u>4900 Clark Drive K.C. Kansas</u>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary occlusion</u><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>arterosclerosis</u><br>DUE TO (c) _____<br>INTERVAL BETWEEN ONSET AND DEATH<br><u>2-3 hrs</u><br><u>10 yrs</u> |  |   |   |  |  |   |  |
| 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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>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.)   |  |   |  |
| 20c. TIME OF INJURY<br>Hour _____ a.m. _____ p.m. Month, Day, Year _____   |  | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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   |  |
| 21. I attended the deceased from <u>1959</u> to <u>4-11-1960</u> and last saw her <u>alive</u> on <u>March 20, '60</u><br>Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.   |  |   |   |  |  |   |  |
| 22a. SIGNATURE <u>L. E. Miller</u> (Degree or title)   |  |   |   | 22b. ADDRESS <u>K.C. Mo</u>  |  | 22c. DATE SIGNED <u>4/13/60</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Removal</u>  |  | 23b. DATE <u>4-14-1960</u>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Mt. Calvary Cem.</u>  |  | 23d. LOCATION (City, town, or county) (State)<br><u>Kansas City, Kansas</u>                                     |  |
| 24. FUNERAL DIRECTOR ADDRESS<br><u>C. H. Blackman Son Inc. W.C. Mo.</u>  |  |   |   | 25. DATE RECD. BY LOCAL REG.<br><u>4-13-60</u>   |  | 26. REGISTRAR'S SIGNATURE<br><u>Neva Minshall</u>   |  |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 W.C. Rinne

Licensed Embalmer No. 4879

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.