

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 1446
Registrar's No. 431

Registration District No. 399 Primary Registration District No. 1002

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(c) Name of hospital or institution:
2537 Troost Avenue
(d) Length of stay: In hospital or institution 40 years
In this community 40 years

3. (a) PRINT FULL NAME Mary S. VanBuren
3. (b) If veteran, name war ---
3. (c) Social Security No. ---

4. Sex F. 5. Color or race W.
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Edmond S. VanBuren
6. (c) Age of husband or wife if alive 69 years
7. Birth date of deceased Jan. 27th 1869

8. AGE: Years 71 Months 0 Days 0
If less than one day --- hr. --- min.

9. Birthplace Ky.

10. Usual occupation Housewife

11. Industry or business ---
12. Name John A. Eads
13. Birthplace Ky.
14. Maiden name Nannie Edmond
15. Birthplace Ky.

16. (a) Informant's own signature E.S. VanBuren
(b) Address 2537 Troost

17. (a) Burial (b) Date thereof 1-30-40
(c) Place: burial or cremation Mirable, Mo.

18. (a) Signature of funeral director R.B. Webb
(b) Address Blue Springs, Mo.

19. (a) Jan. 29, 1940 (b) W.M. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Jackson
(c) City or town Kansas City
(d) Street No. 2537 Troost Avenue
(e) If foreign born, how long in U. S. A.?

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Jan. day 27th
year 1940 hour 12 minute 50 A.M.

21. I hereby certify that I attended the deceased from May 30th, 1938 to Jan. 27th, 1940;
that I last saw her alive on Jan. 26th, 19---;
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of cervix uteri
Due to ---
Due to ---
Other conditions Terminal cardiac failure
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: ---
Of operations ---
Of autopsy None

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) ---
(b) Date of occurrence ---
(c) Where did injury occur? (City or town) (County) (State) ---
(d) Did injury occur in or about home, on farm, in industrial place, in public place? ---

23. Signature W.M. Brown (M. D. or D. O. C. or Hospital) ---
Address --- Date signed ---

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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 this body is not embalmed, above space should be left blank.