

FILED AUG 5 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 25689

Registrar's No. 1714

BIRTH NO.		REG. DIST. NO. 317		PRIMARY REG. DIST. NO. 6076	
1. PLACE OF DEATH a. COUNTY <b>ST. LOUIS</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MISSOURI</b> b. COUNTY		
b. CITY (If outside corporate limits, write RURAL and give township) <b>Koch Rural</b>		c. LENGTH OF STAY (In this place) <b>93 days</b>	c. CITY (If outside corporate limits, write RURAL and give township) <b>ST LOUIS</b>		211, 9
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>ROBT. KOCH HOSP.</b>			d. STREET ADDRESS (If rural, give location) <b>11 1323 NORTH SARAH</b>		
3. NAME OF DECEASED (Type or Print) a. (First) <b>MARY</b>		b. (Middle) <b>ELIZABETH</b>		c. (Last) <b>VAN BUREN</b>	
4. DATE OF DEATH (Month) (Day) (Year) <b>July 13, 1950</b>		5. SEX <b>Female</b>		6. COLOR OF RACE <b>Negro</b>	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>SINGLE (1)</b>		8. DATE OF BIRTH <b>Aug. 26, 1921</b>		9. AGE (In years last birthday) <b>28</b> If under 1 year: Months Days If under 2 hrs: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WAITRESS</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>GREENVILLE MISS</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13a. FATHER'S NAME <b>DAVID VAN BUREN</b>		13b. MOTHER'S MAIDEN NAME <b>ALBERTA INGRAM</b>	
14. NAME OF HUSBAND OR WIFE		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>500-18-9583</b>	
17. INFORMANT'S SIGNATURE OR NAME <b>Robert Karl Hosp Record</b>		17. ADDRESS		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <b>Pulmonary Tuberculosis</b>	
19. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>002X</b>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>April 11, 1950</b> , to <b>July 13, 1950</b> , that I last saw the deceased alive on <b>July 13, 1950</b> , and that death occurred at <b>1:55 P. m.</b> , from the causes and on the date stated above.					
23a. SIGNATURE <b>Frank Cohen</b>		23b. ADDRESS <b>Robert Karl Hosp. Koch</b>		23c. DATE SIGNED <b>July 14/50</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>July 19/50</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Sheswood Cem.</b>	
24d. LOCATION (City, town, or county) (State) <b>St Louis MO</b>		24e. DATE REC'D BY LOCAL REG. <b>7-15-50</b>		24f. REGISTRAR'S SIGNATURE <b>Herbert R. Fowler</b>	
25. FUNERAL DIRECTOR'S SIGNATURE <b>F. A. Green</b>		25. ADDRESS <b>4214 Delmar</b>			

BLM

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed *F. A. Green*

Licensed Embalmer No. 2963

P. O. Address 4214 Delmar

**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, fact should be so stated above.