MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

9159

File No. 1339
Registered No.

1. PLACE OF DEATH

County: Jackson — Registration District No. 599
Township: Kaw — Primary Registration District No. 1002
City: Kansas City (No. General Hospital St. Ward)

2. FULL NAME Edith E. Mabery

(a) Residence. No. 1240 Jefferson St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Female	White	Single

5a. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF ---

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 8, 1912

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	16	1	16	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: at home
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (CITY OR TOWN) Fort Scott
(STATE OR COUNTRY) Kansas

PARENTS

10. NAME OF FATHER Paul Mabery
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Kansas
12. MAIDEN NAME OF MOTHER Maggie Mc Nerney
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ill
(STATE OR COUNTRY)

14. INFORMANT Paul Mabery
(Address) 1240 Jefferson

15. FILED 3/25, 1928 M. M. Crowe
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 24 1928

17. I HEREBY CERTIFY, That I attended deceased from Deputy Coroner
, 19, to , 19
that I last saw h. alive on , 19, and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Septic Abortion
General Peritonitis
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? yes
WHAT TEST CONFIRMED DIAGNOSIS? Autopsy
(Signed) Hal Carlaugh, M. D.
3/24, 1928 (Address) Deputy Coroner

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Forest Hill	3/26/28 19

20. UNDERTAKER	ADDRESS
R. O. Lindsey & Sons	City

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 BLACK INK—DO NOT FOLD

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. 1339

City..... (No. General Hospital St. ..... Ward)

2. FULL NAME Edith E Mahery

(a) Residence. No..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

14. INFORMANT .....
(Address)

15. FILED 3/25, 1928 M. M. Crowe REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-24-1928

17. I HEREBY CERTIFY, That I attended deceased from Duty Coroner, 19.....
that I last saw h.....alive on....., 19....., and that death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Septic abortion
General septicemia
X X
.....(duration).....yrs.....mos.....ds.

CONTRIBUTORY (SECONDARY) Self-induced
.....(duration).....yrs.....mos.....ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? 140
DID AN OPERATION PRECEDE DEATH? ..... DATE OF.....
WAS THERE AN AUTOPSY? Yes
WHAT TEST CONFIRMED DIAGNOSIS? Autopsy
(Signed) [signature], M.D.
, 19 (Address) Deputy Coroner

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

WRITE PLAINLY, WITH INFADING INK—THIS IS A PERMANENT RECORD
item of information should be carefully supplied. AGE should be [illegible] PHYSICIAN [illegible] DEATH in plain [illegible], so that it may be properly classified. Ex[illegible] OCCUPATION is very important.
[illegible]ERS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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