

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-001867

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 355

STATE FILE NUMBER

AMENDED

**FILED FEB 6 1962**

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		Length of stay in 1b <b>3 years</b>	c. CITY OR TOWN <b>KANSAS CITY</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>V A HOSPITAL</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>5622 EAST 11TH</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <b>TED FRANCIS MABERY</b>			4. DATE OF DEATH Month Day Year <b>January 18, 1962</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>8-27-10</b>	9. AGE (last birthday) <b>51</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Steep roofer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Ft. Scott, Kansas</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	

13a. FATHER'S NAME <b>Paul Mabery</b>		13b. MOTHER'S MAIDEN NAME <b>Maggie McNerey</b>		14. NAME OF HUSBAND OR WIFE <b>---</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WWII</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Harold Mabery, Oak Grove, Mo.</b> <b>VA Hospital Official Records, K.C. Mo.</b>	

18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Severe bilateral bronchopneumonia with abscesses**

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) **Bronchogenic carcinoma, right lower lobe with metastases to cerebellum and pons**

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 <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 Hour a.m. p.m. Month, Day, Year		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input 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. **VA** attended the deceased from **December 29, 1961** to **January 18, 1962** and last saw him **alive on** **2:15** p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

Death occurred at

22a. SIGNATURE (Degree or title) <b>S. H. CHOY, M.D.</b>		22b. ADDRESS <b>VA Hospital, Kansas City, Mo.</b>		22c. DATE SIGNED <b>1-19-62</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Jan. 20, 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery ; Kansas City Missouri</b>	
23d. LOCATION (City, town, or county) (State)		24. FUNERAL DIRECTOR <b>D.W. Newcomer's Sons, Kansas City</b>		25. DATE RECD. BY LOCAL REG. <b>1-20-62</b>	
26. REGISTRAR'S SIGNATURE <b>Ruth Long</b>					

(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 DATE AMENDED  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 SHOULD READ  
 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 me,

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*Harold L. Eckert*

Licensed Embalmer No. 1551

P. O. Address *H. Eckert*

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.