

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

Do not use this space.

File No. 5589175
Registered No. _____
St. _____ Ward _____

1. PLACE OF DEATH

County Shelby Registration District No. 30
Township _____ Primary Registration District No. 1
City Shelbina (No. 43012) St. _____ Ward _____

2. FULL NAME

Harlan Keith Raby
(a) Residence No. _____ St. _____ Ward _____
(Usual place of abode)

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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Single

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

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

Dec 19 27

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, _____ hrs. or _____ min.

5

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)

Shelbina Mo.

10. NAME OF FATHER

Harvey H Raby

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ill

12. MAIDEN NAME OF MOTHER

Margaret D Kinkel

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Shelby Co Mo

14. INFORMANT

Harvey H Raby
(Address) Shelbina Mo

15. REGISTRAR

Jan 28 Madge Gooch
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

Dec 24 1927

17.

I HEREBY CERTIFY That I attended deceased from Dec 23, 1927 Dec 23, 1927 that I last saw h. v. x. alive on Dec 23, 1927, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

malformation, Hydrocele of pleura protruding thru intercostal space, left side
(duration) yrs. mos. 5 ds.

CONTRIBUTORY (SECONDARY)

136

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) W. J. Smith, M. D.

. 19 (Address) Shelbina, Mo.

*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

100 Ft. Can

DATE OF BURIAL

Dec 24 1927

20. UNDERTAKER

St Hayes Shelbina

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.

