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.

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

Do not use this space.

14762

**1. PLACE OF DEATH**

County ..... Registration District No. 791 File No. .....

Township ..... Primary Registration District No. 1003 Registered No. 4171.

City St Louis Mo. (No. ..... ISOLATION HOSPITAL St. ..... Ward)

**2. FULL NAME** Elia Marie Raby

(a) Residence. No. 3109 Cass Ave. St., 20 Ward. (If nonresident, give city or town and State)
(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.

**PERSONAL AND STATISTICAL PARTICULARS**

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 18-1922

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

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

9. BIRTHPLACE (CITY OR TOWN) St Louis, Mo.
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Alex Raby

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Mo.
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Esther McCoy

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Mo.
(STATE OR COUNTRY)

14. INFORMANT [signature]
(Address) ISOLATION HOSPITAL

15. FILED APR 25 1930 Max C Starkey REGISTRAR

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**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-25 1930

17. I HEREBY CERTIFY, That I attended deceased from 4-22, 1930, to 4-25, 1930 that I last saw her alive on 4-24, 1930 and that death occurred, on the date stated above, at 12:15 A.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Laryngeal Diphtheria
10
93A (duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (SECONDARY) Acute Myocarditis
(duration) ..... yrs. ..... mos. 2 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH .....
8 DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) [signature], M. D.
4-25, 1930 (Address) ISOLATION HOSPITAL

*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 |
|---|---|
| St Matthews Cem. | Apr 26 1930 |

| 20. UNDERTAKER | ADDRESS |
|---|---|
| E. J. Schnur | 3125 Lafayette av. |