

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

Do not use this space.

8730

1. PLACE OF DEATH

County.....

Registration District No.

791

Township.....

Primary Registration District No.

1003

City.....

(No.)

2332

Hickory

File No.

Registered No.

2330

St.

Ward)

2. FULL NAME

Raymond Scheybal

(a) Residence, No.

2332 Hickory

St.

22 Ward.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Yrs.

mos.

da.

How long in U.S., if of foreign birth?

Yrs.

mos.

da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

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)

Jan. 4 - 1925

7. AGE

YEARS

MONTHS

DAY

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

1

2

1

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

none

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

St. Louis

(STATE OR COUNTRY)

Mo

10. NAME OF FATHER

Fred Scheybal

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Massena

12. MAIDEN NAME OF MOTHER

Stella Frank

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Mo

14.

INFORMANT (Address)

Fred Scheybal
2330 Hickory St

15.

FILED

- 7 - 1927

Wm C Starkopf

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

Mar 5 1927

17.

I HEREBY CERTIFY, That I attended deceased from Illness Feb 27, 1927, to Mar 5, 1927 that I last saw him alive on 3 - 4, 1927, and that death occurred, on the date stated above, at 10:55 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

lobar pneumonia
106 1010

CONTRIBUTORY (SECONDARY)

Nothing

(duration) Yrs. mos. 5 da. 18 da.

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) James M. Harnes, M.D.
(Address) 2005 AS Jefferson Ave.

*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

High Ridge Mo

Mar 6 1927

20. UNDERTAKER

W. B. May dell

ADDRESS

1926 Allen

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.

REPRODUCED FROM ORIGINAL WITH UNFADING INK—THIS IS A PERMANENT RECORD

etno blue

etno blue

etno blue

**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. 291 File No.
 Township..... Primary Registration District No. 1003 Registered No. 2269
 City St. Louis St. Ward.....

2. FULL NAME

Raymond Scheybal
 (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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S
(Specify the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 4 - 1925

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
2 2 23 1

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).....

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 May 6 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 5 1927

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

..... (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..... DATE OF.....
 WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS.....
 (Signed)....., M. D.
 , 19 (Address)

*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL..... DATE OF BURIAL..... 19.....

20. UNDERTAKER..... ADDRESS.....

SUPPLEMENTARY

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

PERMANENT RECORD

0240-5