

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

Do not use this space.

20085

1. PLACE OF DEATH

County.....
Township.....
City *St. Louis* (No.....)

Registration District No. *791*
Primary Registration District No. *1003*

File No.....
Registered No. *5748*
St..... Ward.....

2. FULL NAME

(a) Residence. No. *4116 Lusk* St., *11* 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 *Male* 4. COLOR OR RACE *Colored* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Married*

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF *Josephine Shably*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *March 8-1878*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
31 2 9

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Laborer*
(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) *Miss*

10. NAME OF FATHER

William Shably

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) *Miss*

12. MAIDEN NAME OF MOTHER

Jamie Stenard

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) *Miss*

14.

INFORMANT *Josephine Shably*
(Address) *4116 Lusk St.*

FILED *MAY 25* 19*28* *Wm. C. Stanley* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *5/17/28* 19*28*

17. I HEREBY CERTIFY, That I attended deceased from *5/15/28* to *5/17/28*, and that I last saw him alive on *5/16/28*, and that death occurred, on the date stated above, at *107 1/2*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Phthisis pulmonalis
Acute (duration) *2 3/4* yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

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. *Physical findings*
(Signed) *J. T. Boxer* M. D.

5718, 19*28* (Address) *2380 Murray*

*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

Greenwood

May 26, 1928

20. UNDERTAKER

ADDRESS

Reverent - son

2700 Wash Pl.

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.

237
2
2
2

