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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 14 1947
318

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
Registration District No. _____ Primary Registration District No. **1003**

11433
State File No. _____
Registrar's No. **3199**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County _____
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
City Hospital #1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **3 Days** (Specify whether
In this community **3 Months** years, months or days)

3. (a) PRINT FULL NAME **John T. Ravo**
(b) If veteran, name war **No ne** (c) Social Security No. **498-24-0031**

4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **Clochilda Peirick** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Dec. 2, 1863**
(Month) (Day) (Year)

8. AGE: Years **83** Months **3** Days **23** If less than one day _____ hr. _____ min.

9. Birthplace **Union Mo.**
(City, town, or county) (State or foreign country)
10. Usual occupation **Farmer**

11. Industry or business _____
MOTHER FATHER { 12. Name **Theodore Ravo**
13. Birthplace **Union Mo.**
(City, town, or county) (State or foreign country)
14. Maiden name **Clochilda Peirick**
15. Birthplace **Union Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Veronica Gilbert**
(b) Address **5617 Hodimon**

17. (a) Burial or cremation **burial** Date thereof **March 28, 1947**
(b) Place: burial or cremation **St. Nefer, Mo. Cemetery**

18. (a) Signature of funeral director **Collier Funeral Home**
(b) Address **1233 1/2 Charles Rd.**

19. (a) Date received local registrar **MAR 26 1947** (b) Registrar's signature **J. F. Bredack**

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **St. Louis 96**
(c) City or town **St. Louis Jennings**
(If outside city or town limits, write "RURAL")
(d) Street No. **5617 Hodimon Ave.**
(If rural, give location)
(e) Citizen of foreign country? **No.** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **March** day **25**
year **1947** hour **11:28** minute **00** P.M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Coronary Occlusion
arteriosclerosis
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) **7/4**

Major findings:
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place) (e) Means of injury **3**
23. Signature **Arthur E. High** (Date or other) _____
Address _____ Date signed **3/24/47**

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed..... *Speldon Collier*

Licensed Embalmer No. *3382*

P. O. Address *10123 St. Charles Rd*

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 this body is not embalmed, fact should be so stated above.