

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

# 59-026338

FILED VS AUG 11 1959

Registration District No. 296 Primary Registration District No. 1 Registrar's No. 304 STATE FILE NUMBER

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <b>St. Francois</b>		b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Francois Township</b>		a. STATE <b>Missouri</b>		b. COUNTY <b>City of St. Louis</b>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>State Hospital No. 4</b>		Length of stay in 1b <b>2Y; 1M; 3das.</b>		c. CITY OR TOWN <b>St. Louis</b> <del>4220 McPherson</del>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS <b>4220 McPherson</b>		(If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First <b>NORA</b>		Middle <b>ANN</b>		Last <b>RAVO</b>		Month Day Year <b>August 1, 1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>March 30, 1890</b>	9. AGE (last birthday) <b>69</b>	IF UNDER 1 YEAR Months <b>4</b> Days <b>1</b>	IF UNDER 24 HR Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Cape Girardeau, Mo.</b>		11. BIRTHPLACE (City and state or country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY	
13a. FATHER'S NAME <b>Thomas Jefferson Lacy</b>			13b. MOTHER'S MAIDEN NAME <b>Mary Tripp</b>		14. NAME OF HUSBAND OR WIFE <b>John Ravo</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT Address <b>Records, State Hospital No. 4, Farmington, Mo.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b>						<b>2 das.</b>	
DUE TO (b) <b>Hypertension</b>						<b>Unknown</b>	
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Psychosis with cerebral arteriosclerosis.</b>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION		COUNTY	STATE		
21. I attended the deceased from <b>April 21, 1959</b> to <b>August 1, 1959</b> and last saw her alive on <b>August 1, 1959</b> Death occurred at <b>7:00 A. M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <i>John A. Brennan M.D.</i>				22b. ADDRESS <b>State Hospital No. 4 Farmington, Missouri</b>		22c. DATE SIGNED <b>8-1-59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>August 4, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Hope Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Missouri</b>			
24. FUNERAL DIRECTOR <b>Hoffmeister Funeral Home, St. Louis, Mo.</b>		ADDRESS <b>814 So. Broadway</b>		25. DATE RECD. BY LOCAL REG. <b>Aug 4, 1959</b>		26. REGISTRAR'S SIGNATURE <i>Evelyn Redloff</i>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

MAR 22 1960

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Paul H. Dupal

Licensed Embalmer No. 4120

P. O. Address Farmington

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.