

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 3 1959 *317*

59-027527

Registration District No. *544* Primary Registration District No. *544* Registrar's No. *1985* STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY St. Louis				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before a. STATE Missouri b. COUNTY St. Louis, County												
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kirkwood		Length of stay in 1b 1 day		c. CITY OR TOWN Richmond Heights		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>										
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph Hospital			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 8726 Sierra Dr.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Cynthia Middle Jean Last Ravens				4. DATE OF DEATH Month July Day 23 Year 1959												
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>		8. DATE OF BIRTH 7/23/59	9. AGE (last birthday) 19	IF UNDER 1 YEAR Months 19 Days 19 Hours 19 Min. 19	IF UNDER 24 HR Hours 19 Min. 19									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----			10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (City and state or country) Kirkwood, Mo.		12. CITIZEN OF WHAT COUNTRY USA									
13a. FATHER'S NAME Jack Lee Ravens			13b. MOTHER'S MAIDEN NAME Carolyn Due			14. NAME OF HUSBAND OR WIFE -----										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) -----			16. SOCIAL SECURITY NO. -----		17. INFORMANT Address Mrs. Jack Ravens 8726 Sierra Dr.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bitateral Pneumonia							INTERVAL BETWEEN ONSET AND DEATH 19 hrs.									
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) meningeocele, open																
DUE TO (c) Large Spina Bifida, Lumbars area																
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Mongoloid type absence of frontal bone of skull							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 checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DEATH (BE HOW/INJURY) OCCURRED. (Enter date of injury in PART I or PART II of item 18.) deformity of both ankles												
20c. TIME OF INJURY Hour AM Month, Day, Year July 23, 59		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 Manchester Rd.		COUNTY		STATE	
21. I attended the deceased from 5:28 July 23, 59 to July 24, 59 and last saw her July 24, 59 alive on July 24, 59 Death occurred at 5:28 AM on the date stated above, and to the best of my knowledge, from the causes stated.																
22a. SIGNATURE Michael Sulick M.D. (Degree or title)				22b. ADDRESS 9012 Manchester Rd.				22c. DATE SIGNED 7-24-59								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7/25/59		23c. NAME OF CEMETERY OR CREMATORY St. John Cem.				23d. LOCATION (City, town, or county) (State) Bellefontaine, Mo.								
24. BURIAL DIRECTOR ADDRESS Schrader Funeral Home, Ballwin, Mo.				25. DATE RECD. BY LOCAL REG. 7-24-59		26. REGISTRAR'S SIGNATURE John C. Murphy M.D.										

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed Richard Popp

Licensed Embalmer No. 4589

P. O. Address Baltimore

Not embalmed

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.