

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.

JAN 12 1940

731

Registration District No. _____

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County MO.
(b) City or town ST LOUIS
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: ST LUKES HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME THERESA RAVAGNANI 125

8. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife ALBERT RAVAGNANI 6. (c) Age of husband or wife if alive 45 years
7. Birth date of deceased MAY 31 1893
(Month) (Day) (Year)

8. AGE: Years 46 Months 6 Days 25 If less than one day _____ hr. _____ min.

9. Birthplace ILL
(City, town, or county) (State or foreign country)

10. Usual occupation AT HOME

11. Industry or business _____

12. Name Wm. BORMAN

13. Birthplace ILL
(City, town, or county) (State or foreign country)

14. Maiden name CATHARINE M. LAUGHLIN
(City, town, or county) (State or foreign country)

15. Birthplace ILL
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Wm Borman

(b) Address 4640 DELMAR BLVD

17. (a) BURIAL (b) Date thereof 12-28-1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY

18. (a) Signature of funeral director L M Mullen

(b) Address 5165 DELMAR BLVD

19. (a) DEC 27 1939 (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County 1
(c) City or town ST LOUIS 12
(If outside city or town limits, write "RURAL")
(d) Street No. 4643 DELMAR BLVD
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 26
year 1939 hour 4 minute 5 P M.

21. I hereby certify that I attended the deceased from Dec. 25
1939 to Dec. 26 1939
that I last saw her alive on Dec. 26 1939
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of cervix Duration 6mo.

Due to _____

Due to _____

Other conditions Hypertensive Cardio-vascular disease ?
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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 _____

28. Signature Geo. W. Stuever (M. D. certifier)

Address St. Luke's Hosp. Date signed 12-27-39

Duration
6mo.
PHYSICIAN
Underline the cause to which death should be charged statistically

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

John Ketter

Licensed Embalmer No. *3880*

P. O. Address *St. Louis Mo.*

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, above space should be left blank.