S. No. 2
OM—5-43
v. 5-17-39
I X36671

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

#27918

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 30 1944

Registration District No. 18

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 29843
8219

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Louis City Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 mos-11 days (Specify whether
In this community 0
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 3677 Olive St.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Roman Ravelo

3. (b) If veteran, name war None

3. (c) Social Security No. Unknown

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Katherine Ravelo

6. (c) Age of husband or wife if alive 20 years

7. Birth date of deceased About 1907
(Month) (Day) (Year)

8. AGE: Years About 37 | Months | Days | If less than one day hr. 0 min.

9. Birthplace Unknown Philippine Islands
(City, town, or county) (State or foreign country)

10. Usual occupation Waiter

11. Industry or business Park Plaza Hotel

FATHER
12. Name Unknown
13. Birthplace Unknown Unknown 9
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant Katherine Ravelo
(b) Address 3677 Olive St.

17. (a) Burial (b) Date thereof 9-28-44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation St. Matthews Cemetery

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.

19. (a) SEP 26 1944 (b) J. F. Bridget
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 24th
year 1944 hour 3:00 minute P. M.

21. I hereby certify that I attended the deceased from 6/13/44
, 19 , to Sept. 24th, 1944
that I last saw him alive on Sept. 24th, 1944
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Tuberculosis of vertebral thoracic 203	6 mo
Due to: complete paralysis below Thoracic 203	4 mo
Due to: Lungs not involved	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations as above
Of autopsy none

16

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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature D. J. Verda (M. D. or other)
Address 1515 Lafayette Date signed 9/25/44

(Licensed Embalmer's Statement on Reverse Side)

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 B. W. Wilkinson

Licensed Embalmer No. 3575

P. O. Address.....

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.