

FILED OCT 29 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **38025**
9722
Registrar's No.

REG. DIST. NO. **318**

PRIMARY REG. DIST. NO. **1003**

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| BIRTH NO. | | REG. DIST. NO. 318 | | PRIMARY REG. DIST. NO. 1003 | | State File No. 38025 9722 | |
| 1. PLACE OF DEATH a. COUNTY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY | | | |
| b. CITY (If outside corporate limits, write RURAL and give township) St. Louis | | c. LENGTH OF STAY (in this place) 10 days | | c. CITY OR TOWN St. Louis | | d. In Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Bethesda Hospital | | | | e. STREET ADDRESS (If rural, give location) 3621 Gasconade Street | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) Walter | | b. (Middle) J. | | c. (Last) Ravold | | 4. DATE OF DEATH (Month) (Day) (Year) Oct. 17, 1957 | |
| 5. SEX M. | | 6. COLOR OR RACE W. | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) M. | | 8. DATE OF BIRTH May 24, 1880 | |
| 9. AGE (In years last birthday) 77 | | IF UNDER 1 YEAR Months 4 Days 23 | | IF UNDER 18 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13a. FATHER'S NAME Arthur J. Ravold | | 13b. MOTHER'S MAIDEN NAME Mary Hunn | | 14. NAME OF HUSBAND OR WIFE Mrs. Marie Ravold | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 488-01-0230 | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Marie Ravold, 3621 Gasconade St. | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary heart failure ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) arteriosclerotic heart disease DUE TO (c) hypertension generalized arteriosclerosis II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Pneumo-pneumonia | | | | INTERVAL BETWEEN ONSET AND DEATH 7/19 to 10/17 several years | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION 420.0 | | | | 20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from 7/19 , 19 57 , to 10/17 , 19 57 , that I last saw the deceased alive on 10/16 , 19 57 , and that death occurred at 1:32 m. , from the causes and on the date stated above. | | | | | | | |
| 23a. SIGNATURE (Degree or title) Thomas C. Pordwell M.D. | | | | 23b. ADDRESS 4660 Maryland | | 23c. DATE SIGNED 10/17/57 | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24b. DATE Oct. 19, 1957 | | 24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery | | 24d. LOCATION (City, town, or county) (State) St. Louis, Missouri | |
| DATE REC'D BY LOCAL REG. OCT 17 '57 | | REGISTRAR'S SIGNATURE Carl Smith | | FUNERAL DIRECTOR'S SIGNATURE Walter J. Donnelly | | ADDRESS 3840 Lindell Blvd. | |

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

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 _____, Student Embalmer No. _____ working under my personal supervision..

Student _____
Signature of Student Embalmer

Signed _____
Licensed Embalmer No. _____

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