

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.

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

791
1003

32886
Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No.....
(b) Township..... Primary Registration District No.....
(c) City St. Louis, Mo. (d) Street No. Central Hospital St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred 10 yrs. 6 mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

William H. Ouzts Jr.

(a) Residence, No. 1125 E. Grand St. 9
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 23rd, 1921
7. AGE YEARS 16 MONTHS 5 DAYS 1 If LESS than 1 day, hrs. or min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Student
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) Little Rock,
(STATE OR COUNTRY) Arkansas

FATHER 13. NAME William H. Ouzts Sr.
14. BIRTHPLACE (CITY OR TOWN) Edgefield,
(STATE OR COUNTRY) South Carolina

MOTHER 15. MAIDEN NAME Leonora Howell
16. BIRTHPLACE (CITY OR TOWN) N. Little Rock,
(STATE OR COUNTRY) Arkansas

17. INFORMANT William H. Ouzts Sr.,
(ADDRESS) 1125 E. Grand Blvd.

18. BURIAL, CREMATION, OR REMOVAL
PLACE Little Rock, Ark? DATE Sept. 26th, 1937

19. FUNERAL DIRECTOR Albert H. Hoppe Inc.,
(ADDRESS) 429 N. Euclid Avenue

20. SEP 24 1937 19 Joe Bredeck
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) September 24, 37

22. I HEREBY CERTIFY, That I attended deceased from Sept 19 1937, to Sept 24 1937
I last saw him alive on Sept 24 1937 Death is said to have occurred on the date stated above, at 6:45 A.M.
The principal cause of death and related causes of importance were as follows:

Beriberi
a gangrenous appendix
Date of onset
Other contributory causes of importance:

Name of operation Appendectomy Date of Sept 29, 37
What test confirmed diagnosis? clinical Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury 19.....
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify
(Signed) J. H. Wooten M. D.
(Address) 4518 Washington Ave

STATEMENT BY LICENSED EMBALMER

I, Benj. C. Duncan, Licensed Embalmer No. 2272

hereby certify that the body recorded on the reverse side of this certificate was embalmed by Me

L. E.

No. _____ or by _____, Registered Apprentice No. _____
working under my personal supervision.

Signed

Benj. C. Duncan

Licensed Embalmer No. 2272

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.)