

FILED VS OCT 19 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 9218**

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis Mo.		c. CITY OR TOWN ST. LOUIS, MO	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis City Hosp. # 1		d. STREET ADDRESS (If outside, give location) 2 123 0' FALLON	

3. NAME OF DECEASED (Type or print) First GEROME Middle OUSLEY Last			4. DATE OF DEATH Month Aug. Day 27 Year 1959		
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5. SEX MALE	6. COLOR OR RACE negro	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8/26/59	9. AGE (last birthday) Months _____ Days _____	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hour 17 Minute 58
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10a. USUAL OCCUPATION (Give kind of work done during NONE working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY NONE	11. BIRTHPLACE (City and state or country) ST. LOUIS, MO.	12. CITIZEN OF WHAT COUNTRY U.S.A
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13a. FATHER'S NAME JOE NATHAN OUSLEY	13b. MOTHER'S MAIDEN NAME OCIE PHILLIPS	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war no dates of service)	16. SOCIAL SECURITY NO. none	17. INFORMANT ST. LOUIS CITY HOSP. #1. Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. IMMEDIATE CAUSE (a) Prematurity DUE TO (b) congenital steletosis DUE TO (c) 762.5		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input 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. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year	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 COUNTY _____ STATE _____
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21. I attended the deceased from 8/26/59 to 8/27/59 and last saw <input checked="" type="checkbox"/> him alive on 8/27/59 Death occurred at 6:15 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE R. James Vaccarella, M.D. (Degree or title)	22b. ADDRESS 1515 Lafayette Ave.	22c. DATE SIGNED 8/27/59
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 10-31-59	23c. NAME OF CEMETERY OR CREMATORY Anatomical Board	23d. LOCATION (City, town, or county) St. Louis, Mo. (State)
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24. FUNERAL DIRECTOR Rowland Aker 4104 Manchester ADDRESS	25. DATE RECD. BY LOCAL REG. OCT 8 '59	26. REGISTRAR'S SIGNATURE Loan Smith, M.D.
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

mfb

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.