

No. 2  
1/47  
5-17-39  
XV

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH  
1003

State File No. 28946  
Registrar's No. 8192

National Office of Vital Statistics  
FILED SEP 8 3 1947  
Registration District No. 3197

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

1. PLACE OF DEATH:  
(a) County.....  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Honor G Phillips Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 days (Specify whether  
In this community.....  
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. 1025 Cole St  
25 (If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME Guy Couzart (Couzart)  
3. (b) If veteran, name war..... 3. (c) Social Security No. ....

4. Sex Male 2/ 5. Color or race Col. 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Onie Couzart 6. (c) Age of husband or wife if alive 51 years  
7. Birth date of deceased November 22, 1891  
(Month) (Day) (Year)

8. AGE: Years 55 Months 9 Days 2 If less than one day  
.....hr. ....min

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

10. Usual occupation unknown

11. Industry or business.....  
12. Name Harvey Couzart  
13. Birthplace Unknown  
(City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Onie Couzart  
(b) Address 1025a Call Street

17. (a) Burial (b) Date thereof 8-30-47  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director E. B. Roounce  
(b) Address 1221 N. Grand Avenue  
19. (a) AUG 28 1947 (b) J. F. Bredick  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 24  
year 1947 hour 3 minute 50 A. M.

21. I hereby certify that I attended the deceased from Aug. 21, 1947, to Aug. 24, 1947,  
that I last saw h. im. alive on August 24, 1947,  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Thrombosis if  
Undet.

Due to.....  
Due to..... if

Other conditions None  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations.....  
Of autopsy No

Duration  
PHYSICIAN  
Underline the cause of 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?.....

While at work?..... (Specify type of place)  
(a) Means of injury 2  
23. Signature Oscar Daniels (M. D. or other)  
Address 2601 N Whittier Date signed 8/25/47

**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.....

*Eugene Miles*

Licensed Embalmer No.....

*3623*

P. O. Address.....

*1221-7th St*

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.

Registration District No. 318

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County.....  
(b) City or town..... ST. LOUIS  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
  
(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

Guy Courant

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

4. Sex M 5. Color or race B 6. (a) Single, widowed, married, divorced.....

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive.....

7. Birth date of deceased Nov. 22 (Month) (Day) (Year)

8. AGE: Years 55 Months Days If less than one day hr. min.

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

10. Usual occupation unknown

11. Industry or business

MOTHER FATHER

12. Name.....  
13. Birthplace..... (City, town, or county) (State or foreign country)  
14. Maiden name.....  
15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant.....  
(b) Address.....  
17. (a)..... (b) Date thereof..... (Month) (Day) (Year)  
(Burial, cremation, or removal)  
(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....  
(b) Address.....  
19. (a) SEP 19 1941 (b) J. F. Brebeck  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....  
(c) City or town..... (If outside city or town limits, write "RURAL")  
(d) Street No..... (If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept year 1941 hour 12 minute x M.

21. I hereby certify that I attended the deceased from..... to..... 19.....  
that I last saw him..... and that death occurred on the date and hour stated above.  
immediate cause of death.....

Due to.....  
Due to.....  
Other conditions..... (Include pregnancy within 3 months of death)

Major findings:  
Of operations.....  
Of autopsy.....

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?  
  
While at work?..... (Specify type of place) (e) Means of injury.....  
23. Signature..... (M. D. or other)  
Address..... Date signed.....

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

SUPPLEMENTARY

S-28946