

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

15432
15164

791
1003

File No. _____
Registered No. **4566**
St. _____ Ward _____

1. PLACE OF DEATH

County..... Registration District No.....
Township..... Primary Registration District No.....
City St. Louis (No. City 1000)

2. FULL NAME

James Pounds
(a) Residence No. 1913 Allen St., 13 Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 27, 1887

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, — hrs. or — min.
89 | 11 | 22

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Georgia

10. NAME OF FATHER Ed. unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Georgia

12. MAIDEN NAME OF MOTHER unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Georgia

14. INFORMANT (Address) Ed. unknown
City 1000

15. FILED 22 1928 St. Louis REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 28, 1928

17. I HEREBY CERTIFY That I attended deceased from April 6, 1928, to April 27, 1928, that I last saw him alive on April 27, 1928, and that death occurred, on the date stated above, at 3:15 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Myocardial infarction
9/10 (duration) yrs. mos. ds.
9/10 (duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) 9/10 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED? IF NOT AT PLACE OF DEATH, _____

DID AN OPERATION PRECEDE DEATH? DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) [Signature] M. D.
4/20, 1928 (Address) City 1000

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL No. Crematory DATE OF BURIAL 4-23 1928

20. UNDERTAKER [Signature] ADDRESS 3013
[Signature] Insurance

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.

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Pound.