

FILED OCT 26 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35845

State File No.

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 9179

1. PLACE OF DEATH
a. COUNTY _____
2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Missouri b. COUNTY _____

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis c. LENGTH OF STAY (In this place) _____
c. CITY OR TOWN St. Louis d. Is Residence within limits of a city or incorporated town? Yes No

d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION 1208 No. Kingshighway
e. STREET ADDRESS (If rural, give location) 1208 No. Kingshighway 212 1/2

3. NAME OF DECEASED a. (First) Paul b. (Middle) William c. (Last) Pounds 4. DATE OF DEATH (Month) (Day) (Year) Oct. 9, 1954.

5. SEX Male 6. COLOR OR RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 8. DATE OF BIRTH Nov. 27, 1899 9. AGE (In years last birthday) 54 IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 1 HR. Hours _____ Min. _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bartender 10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (City and State or Foreign Country) Flat River, Missouri 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Thomas B. Hunt 13b. MOTHER'S MAIDEN NAME Ethel (Unknown) 14. NAME OF HUSBAND OR WIFE Unknown

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 # 491-14-4248 17. INFORMANT'S SIGNATURE OR NAME. ADDRESS Paul J. Pounds, Jr., 3004 McNair.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____
ANTECEDENT CAUSES DUE TO (b) Branchial Asthma
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) Cardiac Hypertrophy
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.
INTERVAL BETWEEN ONSET AND DEATH _____

19a. DATE OF OPERATION _____ 19b. MAJOR FINDINGS OF OPERATION _____ 20. AUTOPSY? YES 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) 434.3

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 3:35 P. m., from the causes and on the date stated above.

23a. SIGNATURE Dr. Carl Smith (Ink or title) 23b. ADDRESS 1200 Clark 23c. DATE SIGNED 10/11/54

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 24b. DATE Oct. 11, 1954 24c. NAME OF CEMETERY OR CREMATORY St. Matthews Cemetery 24d. LOCATION (City, town, or county) (State) St. Louis, Mo.

DATE REC'D BY LOCAL REG. OCT 11 1954 REGISTRAR'S SIGNATURE Carl Smith MO 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wacker-Heldak U. & P. Co., 3634 Gravois, St. Louis, Mo.

(Licensed Embalmer's Statement on Reverse Side)

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.