

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-003397
STATE FILE NUMBER

2 754
REGISTRAR'S NO.

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH
a. COUNTY _____
b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits
OR TOWN **ST LOUIS,** Yes No
c. FULL NAME OF (If NOT in hospital, give location) Length of stay in 1b
HOSPITAL OR INSTITUTION **ST LUKE'S HOSPITAL**

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE **MISSOURI** b. COUNTY _____
c. CITY OR TOWN **ST LOUIS,** Inside Limits Yes No
d. STREET ADDRESS **1429 SHAWMUT PLACE** (If outside, give location) Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last
WALTER J. POUND

4. DATE OF DEATH Month Day Year
JAN, 21, 1959

5. SEX **MALE** **6. COLOR OR RACE** **WHITE**
7. MARRIED NEVER MARRIED **8. DATE OF BIRTH** **DEC. 24, 1892**
9. AGE (In years last birthday) **66** **10. KIND OF BUSINESS OR INDUSTRY** **GOV'T** **11. BIRTHPLACE** (City and state or country) **ST LOUIS MISSOURI** **12. CITIZEN OF WHAT COUNTRY?** **U.S.A.**

13. FATHER'S NAME **JOHN T. POUND** **14. MOTHER'S MAIDEN NAME** **CATHERINE PHILLIPS**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) **YES** **WORLD WAR I** **16. SOCIAL SECURITY NO.** # _____ **17. INFORMANT** **MARGARET MADDEN** Address **1429 SHAWMUT PL.**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Cerebro Vasacular Accident, suspected**
DUE TO (b) **Thrombocytopenia**
DUE TO (c) **Acute Myelocyte Leukemia**
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) **204.3**
INTERVAL BETWEEN ONSET AND DEATH **One day**
Over 6 mo.

19. WAS AUTOPSY PERFORMED? YES NO

20a. ACCIDENT **SUICIDE** **HOMICIDE** **20b. DESCRIBE HOW INJURY OCCURRED.** (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour Month, Day, Year
a. m. p. m.

20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK **20e. PLACE OF INJURY** (e. g., in or about home, farm, factory, street, office bldg., etc.) _____ **20f. CITY, TOWN, OR LOCATION** _____ **COUNTY** _____ **STATE** _____

21. I attended the deceased from **1/17/59** to **1/21/59** and last saw **him** alive on **1/21/59**
Death occurred at **9:30 P** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) **James G. Nishi, M.D.** **22b. ADDRESS** **St Luke's Hospital** **22c. DATE SIGNED** **1/22/59**

23a. BURIAL, CREMATION, REMOVAL (Specify) **BURIAL** **23b. DATE** **1/26/59** **23c. NAME OF CEMETERY OR CREMATORY** **CALVARY CEMETERY** **23d. LOCATION** (City, town, or county) (State)
ST LOUIS MISSOURI

24. FUNERAL DIRECTOR **STROOT - CARROLL** ADDRESS **4600 NATURAL BRIDGE** **25. DATE RECD. BY LOCAL REG.** **JAN 23 '59** **26. REGISTRAR'S SIGNATURE** **J. Earl Smith, M.D.**
M. J. B.

Use ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE. Coroner cannot certify to a death due to natural causes. diseases in Part I must be causally related.

32
10
56
61
0

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was e
by me, or by Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *M. W. Rueter*.....

Licensed Embalmer No. *4*.....

P. O. Address *St Louis*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
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.