

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 7338

Registration District No. 3079

Primary Registration District No. 547 3079

Registrar's No. 48

FILED MAR 15 1940

1. PLACE OF DEATH:

(a) County Marion
 (b) City or town Hannibal
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: ST Elizabeth Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 8 1/2
 (Specify whether years, months or days)

3. (a) PRINT FULL NAME Edward F. Driscoll

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

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

7. Birth date of deceased Nov 9 1867
 (Month) (Day) (Year)

8. AGE: Years 72 Months 3 Days 29 If less than one day hr. _____ min. _____

9. Birthplace Scottsboro, Canby MO
 (City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

FATHER { 12. Name William Driscoll
 18. Birthplace Caraba
 (City, town, or county) (State or foreign country)

MOTHER { 14. Maiden name W. Brown
 15. Birthplace _____
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Hilma Doherty
 (b) Address 214 S 4th Hannibal MO

17. (a) Burial (b) Date thereof Feb 10-40
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memphis MO

18. (a) Signature of funeral director James J. Powell
 (b) Address Hannibal MO

19. (a) 2-9-40 (b) H. C. Fisher
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
 (c) City or town Memphis MO
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 7
 year 1940 hour 9:10 minute _____ P. M.

21. I hereby certify that I attended the deceased from Jan 7 1940 to Feb 7 1940
 that I last saw him alive on _____, 19____
 and that death occurred on the date and hour stated above.

Immediate cause of death Hypertension -
Myocardial infarction
 Due to _____
 Due to _____
 Other conditions (include pregnancy within 3 months of death) _____

Duration

Major findings: Hypertension
 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) Means of injury _____
 23. Signature J. M. Reardon (M. D. or other)
 Address 100 S. 4th Hannibal MO signed _____

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

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

2/9/40

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 Michael J. O'Connell

Licensed Embalmer No. 3246

P. O. Address Hannibal, Mo

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, above space should be left blank.

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-40
22559

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **7338**

Registration District No. **547**

Primary Registration District No. **3029**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Marion**
(b) City or town **Hannibal**
(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 _____
In this community _____ (Specify whether
years, months or days) 1

3. (a) PRINT FULL NAME **Edw. E. Driscoll**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **m** 5. Color or race **w** 6. (a) Single, widowed, married, divorced **wid**

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

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years **72** Months **2** Days **29** If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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) **12/7/40** (b) **E. M. Rucke**
(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) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb** day **7** year **1940** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____; 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 _____

Duration _____
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 **J. M. Reichmann** (M.D. or Other) _____
Address **Hannibal** Date **Jan 1941**

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

SUPPLEMENTARY

