

REC'D APR 8 1940

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

10337
Do not use this space.

1. PLACE OF DEATH
 (a) County Butler Registration District No. 995
 (b) Township Ash Hill Primary Registration District No. 5134C Registered No. _____
 (c) City FISK (d) Street No. _____ (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME J. H. Driver
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 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 Gizzie Driver
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) _____
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 81 3 8
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. farmer
 9. Industry or business in which work was done, as saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 1 1940
 22. I HEREBY CERTIFY, That I attended deceased from Feb. 29 1940, to _____, 19____
 I last saw him alive on Feb 29, 1940. Death is said to have occurred on the date stated above, at 9 a. m.
 The principal cause of death and related causes of importance were as follows:
Apoplexy
Arterial Sclerosis
 Date of onset 2-27-40

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Acersville, Tenn
 FATHER 13. NAME James Driver
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn
 MOTHER 15. MAIDEN NAME Don't know
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____
 17. INFORMANT (ADDRESS) Wm Driver
Cassatonsville, Mo
 18. BURIAL, CREMATION, OR REMOVAL PLACE Ash Hill DATE March 2 1940
 19. FUNERAL DIRECTOR (ADDRESS) M. S. Shain
Fisk, Mo
 20. FILED Mar 10 1940 Wm Adams
Local Registrar.

Other contributory causes of importance: _____
 Name of operation none Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.
 Manner of injury _____
 Nature of injury _____
 24. Was disease or injury in any way related to occupation of deceased? No
 If so, specify _____
 (Signed) R. J. [Signature], M. D.
 (Address) _____

WRITE PLAINLY, WITH UNFADING INK--THIS IS 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.

50M-7-20-37 I X12004

STATEMENT BY LICENSED EMBALMER

I,, Licensed Embalmer No.....

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

..... L. E.

No..... or by....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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.)

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 10337

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 925

Primary Registration District No. 3134C

Registrar's No.

1. PLACE OF DEATH:

(a) County. Butterfield
(b) City or town. Butterfield
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State. Mo (b) County. Butter
(c) City or town. Brookly
(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.?

3. (a) PRINT FULL NAME John H. Driver

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. year

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

8. AGE: Years 81 Months 3 Days 8 If less than one day, hr. 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) (Burial, cremation, or removal) (b) Date thereof. (Month) (Day) (Year)

(c) Place: burial or cremation.

18. (a) Signature of funeral director.

(b) Address.

19. (a) 5/20/40 (Date received local registrar) (b) Obstetanger (Registrar's signature)

20. DATE OF DEATH. Month mar day 1 year 1940 hour. minute. M.

21. I hereby certify that I attended the deceased from 1940 to 1940 that I last saw him alive on 1940 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.

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 P. J. Tarpley (M. D. or other)

Address Fair Date signed.

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

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

10337