DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 23620

Registration District No. 791 AUG 25 1940

Primary Registration District No. 1003

Registrar's No. 6065

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.

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: BARNES HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 9 days (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County

(c) City or town Girard N.R.
(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.

3. (a) PRINT FULL NAME Albin Driver 616

3. (b) If veteran, name war No.

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Tabitha

6. (c) Age of husband or wife if alive 77 years

7. Birth date of deceased April (Month) 5 (Day) 1864 (Year)

8. AGE: Years 76 Months 3 Days 14 If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name William A. Driver
13. Birthplace Green Co. (City, town, or county) Illinois (State or foreign country)

MOTHER
14. Maiden name Rachel Edwards
15. Birthplace Green Co. (City, town, or county) Illinois (State or foreign country)

16. (a) Informant's own signature Mrs. Tabitha Driver
(b) Address Girard, Illinois.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 7-20-40 (Month) (Day) (Year)
(c) Place: burial or cremation Girard, Ill.

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Ave.

19. (a) JUL 19 1940 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 19
year 1940 hour 1 minute 40 A.M.

21. I hereby certify that I attended the deceased from 7-11-1940, 19, to 7-19-, 1940;
that I last saw him alive on 7-19-, 1940
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Bronchopneumonia	
Due to post-operative; excision of carcinoma of mouth & radical dissection of neck	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings: Of operations Carcinoma of mouth with metastases to cervical lymph nodes
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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature P. N. Anderson (M. D. ~~or other~~)
Address BARNES HOSPITAL Date signed 7-19-40

(Licensed Embalmer's Statement on Reverse Side)

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 J. G. Sullivan

Licensed Embalmer No. 1122

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.