

No. 300  
10-48

FILED JUL 5 - 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

17913

State File No. ....

BIRTH NO. .... REG. DIST. NO. 47 PRIMARY REG. DIST. NO. 3008 Registrar's No. 166

1. PLACE OF DEATH a. COUNTY <b>Callaway</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Callaway</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Fulton</b>		c. CITY OR TOWN <b>Fulton</b>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. LENGTH OF STAY (in this place) <b>1 week</b>		e. STREET ADDRESS (If rural, give location) <b>R.F.D.# 1</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Callaway Hospital</b>			

0140

3. NAME OF DECEASED (Type or Print) a. (First) <b>Bell</b> b. (Middle) <b>Mona</b> c. (Last) <b>Driskell</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>July 1 1955</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>May 19 1884</b>	9. AGE (In years last birthday) <b>71</b>	IF UNDER 1 YEAR: Months <b>1</b> Days <b>12</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Laclede Co, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>

13a. FATHER'S NAME <b>Jacob Womack</b>		13b. MOTHER'S MAIDEN NAME <b>Malissa</b>		14. NAME OF HUSBAND OR WIFE <b>E. L. Driskell</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Dollie Sapp</b> ADDRESS <b>Fulton, Mo R R</b>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Hemorrhage</b>		Antecedent Causes <b>Anterior Arteriosclerotic CVR</b>		<b>11 days</b>	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (b) <b>Anterior Arteriosclerotic CVR</b>		<b>yes</b>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		DUE TO (c)			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>331X</b>			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Nov. 3, 1950, to July 1, 1955, that I last saw the deceased alive on July 1, 1955, and that death occurred at 5:00 P m., from the causes and on the date stated above.

23a. SIGNATURE <b>E. R. Yick</b> (Degree or title)		23b. ADDRESS <b>Fulton, Mo</b>		23c. DATE SIGNED <b>7-2-55</b>	
--	--	--------------------------------	--	--------------------------------	--

24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>July 4 1955</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Concord Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>Rural Callaway Co Mo</b>	
---	--	------------------------------	--	--	--	---	--

DATE REC'D BY LOCAL REG. <b>July 2-1955</b>		REGISTRAR'S SIGNATURE <b>Maretha Lawrence</b> <u>426-</u>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Hallace Funeral Home</b> ADDRESS <b>Fulton Mo</b>	
---	--	---	--	---	--

(Licensed Embalmer's Statement on Reverse Side)

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

1955 8-708

---

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 *Renzil C. Browning*

Licensed Embalmer No. *272*

P. O. Address *Fulton*

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.