

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=63-018486

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1095

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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USE BLACK INK OR TYPEWRITER RIBBON

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FILED APR 16 1963

1. PLACE OF DEATH
a. COUNTY ST LOUIS
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, County. Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Aftton Nursing Home. Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY
c. CITY OR TOWN St. Louis, Inside Limits Yes No
d. STREET ADDRESS (If outside, give location) 3506 Itaska Ave. Reside on Farm Yes No

3. NAME OF DECEASED First Middle Last 4. DATE OF DEATH Month Day Year
James O. Driskill. 3 29 63

5. SEX Male 6. COLOR OR RACE White 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH 2-9-79 9. AGE (last birthday) 84 IF UNDER 1 YEAR IF UNDER 24 HR
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired 10b. KIND OF BUSINESS OR INDUSTRY None. 11. BIRTHPLACE (City and state or country) Henderson Kentucky 12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME Unk. 13b. MOTHER'S MAIDEN NAME Unk. 14. NAME OF HUSBAND OR WIFE Mamie Driskill.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) 17. INFORMANT Address
Cecil Driskill 5432 Nagel Ave.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arterio-Sclerotic Heart Disease INTERVAL BETWEEN ONSET AND DEATH 10yrs
DUE TO (b) Arterio-Sclerotic-Cardio-Vascular Disease & Chronic Brain Syndrome
DUE TO (c) 4200
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Secondary Hypertension PART III. If deceased was female was there a pregnancy in last 90 days.
 Yes No Unknown

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.)
NONE

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

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 1-26-63 to 3-29-63 and last saw him alive on 3-19-63
Death occurred at 3-29-63 6:45 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Allen McDearney M.D. 22b. ADDRESS 860 N. Woodlawn 22c. DATE SIGNED 3-30-63

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial. 23b. DATE 4-1-63. 23c. NAME OF CEMETERY OR CREMATORY Parklawn. 23d. LOCATION (City, town, or county) (State) St. Louis, County Mo.

24. FUNERAL DIRECTOR ADDRESS Southern Funeral Home. 6922 S. Grand Blvd. 25. DATE RECD. BY LOCAL REG. 4-1-63 26. REGISTRAR'S SIGNATURE [Signature]

Affton Nursing Home.
9009 Gravois.
11AM-12Am.

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

Homer Dill

Licensed Embalmer No.

4347

P. O. Address

6300 Grand

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.