

No. 2  
-13-40  
17-39  
XZ3159

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 10899

1. PLACE OF DEATH:

(a) County \_\_\_\_\_

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

(c) Name of hospital or institution: Missouri Pacific Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 12 days  
(Specify whether years, months or days)

In this community 1  
years, months or days

3. (a) PRINT FULL NAME John Francis Driscoll

3. (b) If veteran name war None

3. (c) Social Security No. None

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

6. (b) Name of husband or wife Anna Driscoll 6. (c) Age of husband or wife if alive 1867 years

7. Birth date of deceased Sept. 28  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>73</u>	<u>3</u>	<u>2</u>	hr. _____ min. _____

9. Birthplace St. Louis Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired R. R. Oiler

11. Industry or business \_\_\_\_\_

12. Name John Driscoll

13. Birthplace Ireland  
(City, town, or county) (State or foreign country)

14. Maiden name Ellen Logan

15. Birthplace Ireland  
(City, town, or county) (State or foreign country)

16. (a) Informant John Driscoll

(b) Address 5417 No. Union Ave.

17. (a) Burial (b) Date thereof 1/2/41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address 2117 E. Grand Blvd.

19. (a) DEC 31 1940 (b) J. B. Brudeck  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town St. Louis 7  
(If outside city or town limits, write "RURAL")

(d) Street No. 5417 North Union Street  
(If rural, give location)

(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 31  
year 1940 hour 2 minute 10 A. M.

21. I hereby certify that I attended the deceased from December 19, 1940 to December 31, 1940  
that I last saw him alive on December 31, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage 1 year

Due to Arteriosclerosis  
Hypertension

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Duration

1 year

PHYSICIAN

Underline the cause to which death should be charged statistically.

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy No

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)

(c) Means of injury \_\_\_\_\_

23. Signature H. B. Atherton (M. D. or other) M.D.

Address Missouri Pacific Hosp Date signed 12-31-40

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

MOTHER FATHER

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**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.....

Licensed Embalmer No.....

P. O. Address.....

**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, fact should be so stated above.**