DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 11295

FILED MAR 19 1941

Registration District No. 518

Primary Registration District No. 4574

Registrar's No.

60
00
0

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

1. PLACE OF DEATH:
(a) County McDonald
(b) City or town Anderson
(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 McDonald 60
(c) City or town Anderson
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME EDGAR H. DRISKAL
3. (b) If veteran, name war NO
3. (c) Social Security No.
4. Sex MALE
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Marion Driskal
6. (c) Age of husband or wife if alive 46 years
7. Birth date of deceased January (Month) 20 (Day) 1892 (Year)

8. AGE: Years 49 | Months 0 | Days 18 | If less than one day hr. min.

9. Birthplace Webb City (City, town, or county) MO. (State or foreign country)
10. Usual occupation Engineer
11. Industry or business
FATHER
12. Name Geo. Driskal
13. Birthplace Cape Giardeau (City, town, or county) MO. (State or foreign country)
MOTHER
14. Maiden name Emma Hoffman
15. Birthplace Cape Giardeau (City, town, or county) MO. (State or foreign country)
16. (a) Informant Mrs Marion Driskal
(b) Address Anderson, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-9-41 (Month) (Day) (Year)
(c) Place: burial or cremation Webb City Mo
18. (a) Signature of funeral director M. R. Grow
(b) Address Anderson, Mo.
19. (a) 2-9-41 (Date received local registrar) (b) Mrs Lee Harper (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feby day 7
year 41 hour 5 minute A M.
21. I hereby certify that I attended the deceased from
, 1920 to , 1940
that I last saw him alive on Feby 5, 1941
and that death occurred on the date and hour stated above.

Immediate cause of death Flu with T. B.
Due to Specific cause
Due to
Other conditions None
(Include pregnancy within 3 months of death)
Major findings:
Of operations None
Of autopsy None

Duration

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?
4 to 2 (Specify type of place)
While at work? (e) Means of injury
23. Signature J. T. Fulkerson (M. D. or other) D
Address Anderson Date signed 2/9/41

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6,
District File Number 341-391
Date Filed MAR 6 1941

13

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 M. D. Snow

Licensed Embalmer No. 4034

P. O. Address Anderson, Mo

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

If this body is not embalmed, fact should be so stated above.

S. No. 2B
—4-25-41
I X27852

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 11295

Registration District No. 518 Primary Registration District No. 4574 Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County McDonald

(b) City or town Anderson
(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 (b) County

(c) City or town
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Edgar H Driskal

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 m

6. (b) Name of husband or wife

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

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

8. AGE: Years 49 Months 0 Days 18 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feby day 7
year 1941 hour minute M.

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

Immediate cause of death Flu-with T.B.

Due to T.B. of lungs - both lungs equally affected

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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 J. T. Fulkerson (M. D. or other)

Address Date signed

1941
S-11295