

FILED AUG 21 1944

Registration District No. 38

Primary Registration District No. 3006

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

1. PLACE OF DEATH:

(a) County Boone

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

(c) Name of hospital or institution:
209 W. Broadway
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. 53 Years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Boone

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

(d) Street No. 209 W. Broadway
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME JAMES GODFREY DRISKILL

3. (b) If veteran, name war None

3. (c) Social Security No. 191-11-9085

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Ima Driskill

6. (c) Age of husband or wife if alive 1890 years

7. Birth date of deceased 8 - 7 - 1890
(Month) (Day) (Year)

8. AGE: Years 53 Months 11 Days 14
If less than one day hr. min.

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

10. Usual occupation Furniture Repairman

11. Industry or business

12. Name James H. Driskill

13. Birthplace Cooper Co. Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Mollie Molden

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

16. (a) Informant Mrs. J.G. Driskill

(b) Address Columbia, Mo.

17. (a) Burial (b) Date thereof 7-23-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Columbia Cemetery

18. (a) Signature of funeral director Barber Funeral Service
Columbia, Mo.

(b) Address

19. (a) 7-22-44 (b) Edna H. Barber
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 21
year 1944 hour 12 minute 20 P.M.

21. I hereby certify that I attended the deceased from 7-20-44 to 7-21-44
that I last saw him alive on 7-21-44 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration Two days

Due to 830

Other conditions All for the last yr.
(Include pregnancy within 3 months of death)

Major findings: None Of operations None Of autopsy None

PHYSICIAN

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) No

(b) Date of occurrence

(c) Where did injury occur? No (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? No (Specify type of place) (c) Means of injury None

23. Signature W.D. Stewart M. D. or other M.D.
Address Columbia, Mo. Date signed 7-22-44

1250

RECEIVED
District Health Officer No. 9,
District File Number.....
Date Filed 8-18-77

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. 4132

P. O. Address Columbia, N.C.

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.