

6-2  
8-13  
7-39  
X37823

FILED JUN 25 1945  
Registration District No. **230**

Primary Registration District No. **5823**

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

1. PLACE OF DEATH:

(a) County New Madrid  
(b) City or town Rural, New Madrid, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: No  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community about 12 years  
years, months or days

3. (a) PRINT FULL NAME

ARVEN DRISKILL

3. (b) If veteran, name war No. 3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced \_\_\_\_\_

6. (b) Name of husband or wife MARTHA DRISKILL 6. (c) Age of husband or wife if alive 33 years

7. Birth date of deceased Sept - 11 - 1907  
(Month) (Day) (Year)

8. AGE: Years 37 Months 9 Days 8 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Van Buren Co Ark.  
(City, town, or county) (State or foreign country)

10. Usual occupation Farming

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

12. Name Jefferson Driskill

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

14. Maiden name Margaret Walls

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

16. (a) Informant Martha Driskill

(b) Address Lilbourn

17. (a) Burial (b) Date thereof 6-21-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mounts

18. (a) Signature of funeral director Richard and Co.  
(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County New Madrid  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June, day 19  
year 1945 hour 4:30 minute \_\_\_\_\_ P.M.

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

Immediate cause of death Pulmonary Tuberculosis Duration 4 years

Due to \_\_\_\_\_  
Due to 1368

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

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature L. M. ... (M. D. or other)  
Address Morehouse Date signed 6-9-45

**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 *Leo Helgenuth*.....

Licensed Embalmer No. *3803*.....

P. O. Address *New Rochelle, N.Y.*.....

**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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. July  
Registrar's No. 1

Registration District No. 238 Primary Registration District No. 5823

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

1. PLACE OF DEATH:

(a) County new Madrid  
 (b) City or town Rural new Madrid  
(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 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County New Madrid  
 (c) City or town Lebanon, Mo - Rural  
(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 Arlen Driskill  
 3. (b) If veteran, name war..... 3. (c) Social Security No.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept Year 1945  
 hour..... minute..... M.  
 21. I hereby certify that I attended the deceased from.....  
 to.....  
 that I last saw him.....  
 and that death occurred on the date and hour stated above,  
 immediate cause of death Pulmonary Tuberculosis  
 Duration 4 yr

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 Sept 11  
(Month) (Day) (Year)

8. AGE: Years 37 Months..... Days.....  
If less than one day hr. min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER {  
 12. Name.....  
 13. Birthplace.....  
(City, town, or county) (State or foreign country)  
 14. Maiden name.....  
 15. Birthplace.....  
(City, town, or county) (State or foreign country)

16. (a) Informant Martha Driskill  
 (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 Rushmore Mort Co  
 (b) Address New Madrid, Mo

19. (a) 16-27-45 (b) Richard Jones  
(Date received local registrar) (Registrar's signature)

Due to.....  
 Due to.....  
 Other conditions.....  
(Include pregnancy within 3 months of death)

Major findings:  
 Of operations.....  
 Of autopsy.....

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?

While at work?.....  
(Specify type of place) (c) Means of injury  
 23. Signature J M Lewis (M. D. or other)  
 Address morehouse Date signed 6-28-45

20894