

FILED MAY 29 1947
National Office of Vital Statistics
Registration District No. **318**

Primary Registration District No. **1003**

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:
St. Johns Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 Day**
(Specify whether)

In this community.....
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State..... **Mo.** (b) County.....
(c) City or town..... **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **5862 Cates Ave.**
5 (If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME **Daniel E. Driscoll**
3. (b) If veteran, name war..... 3. (c) Social Security No.

4. Sex **M. 0** 5. Color or race **W. 0**
6. (a) Single, widowed, married, divorced. **Married**
6. (b) Name of husband or wife..... **Edith Driscoll**
6. (c) Age of husband or wife if alive. **45** years
7. Birth date of deceased. **Jan. 16, 1898**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
49 4 5 hr. min.

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

10. Usual occupation..... **Accountant**

11. Industry or business.....

12. Name..... **Daniel F. Driscoll**

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

14. Maiden name..... **Felice Delaney**

15. Birthplace..... **St. Louis St. Mo. 0**
(City, town, or county) (State or foreign country)

16. (a) Informant..... **Edith Driscoll**

(b) Address..... **5862 Cates Ave.**

17. (a) **Burial** (b) Date thereof **5-23-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation..... **Calvary Cemetery**

18. (a) Signature of funeral director..... **Arthur Donnelly**

(b) Address..... **3849 E. Russell**

19. (a) **MAY 21 1947** (b) **F. Russell**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... **May** day **21st.**
year..... **1947** hour..... **4** minute..... **30 P.** M.

21. I hereby certify that I attended the deceased from **May 16-47**
....., 19....., to **May 21-47**
....., 19....., that I last saw h.i.m. alive on **May 20**, 19....., and that death occurred on the date and hour stated above.

Immediate cause of death..... **Nephritis Acute** **5 days**

Due to..... **Pneumonia 2 hrs** **5 days**

Due to..... **108**

Other conditions..... **Septic thrombosis**
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....

Of autopsy.....

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..... **Arthur M. Nelson** (M. D. or other)

Address..... **506 No. Theatre Bldg** Date signed **May 21-47**

Duration
5 days
5 days
?
PHYSICIAN
Underline the cause of which death should be charged statistically.

WRITE PLAINLY—USING ENFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

Wm Marshall

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 *Stanley Marshall*
Licensed Embalmer No. *2868*
P. O. Address *3840 Lindell*

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.