

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State of Missouri No. **58-024351**

FILED JUN 17 1958 REG. DIST. NO. **354** PRIMARY REG. DIST. NO. **6197** Registrar's No. **58**

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| 1. PLACE OF DEATH a. COUNTY TEXAS | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO. b. COUNTY TEXAS | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN BURDINE Twp. | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN BURDINE Twp. 10700 | |
| c. LENGTH OF STAY (in this place) 53 | | d. STREET ADDRESS (If rural, give location) RURAL RT. CAROOL | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION | | | |

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|---------------------------------------------------------------------------------------------------------------|--|---------------------------|--------------------------------------------------------------------------------------|-----------------------------------------------------------------------|--|
| 3. NAME OF DECEASED (Type or Print) a. (First) EFFIE b. (Middle) c. (Last) DRISKILL | | | 4. DATE OF DEATH (Month) (Day) (Year) 6-6-58 | | |
| 5. SEX F | | 6. COLOR OR RACE W | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED | |
| 8. DATE OF BIRTH 11-8-1874 | | | 9. AGE (In years last birthday) 83 IF UNDER 1 YEAR: Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | | 10b. KIND OF BUSINESS OR INDUSTRY | | |
| 11. BIRTHPLACE (State or foreign country) DAVIS CITY, IOWA | | | 12. CITIZEN OF WHAT COUNTRY? USA | | |

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|-----------------------------------------------------------------------------|--|------------------------------------------------|--|-----------------------------------------------------------------------|--|
| 13a. FATHER'S NAME SAM HINKLE | | 13b. MOTHER'S MAIDEN NAME SARAH ROBBING | | 14. NAME OF HUSBAND OR WIFE ELBERT DRISKILL | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT'S SIGNATURE OR NAME LIONEL DRISKILL, CAROOL, MO. | |

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|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------|--|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.</i> | | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary hemorrhage | | INTERVAL BETWEEN ONSET AND DEATH 10 min. | |
| | | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Pulmonary tuberculosis. | | 15 years | |
| | | DUE TO (c) | | | |
| | | II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | |

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|-------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 002X | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | |

22. I hereby certify that I attended the deceased from **July 56, 1958**, to **6/6, 1958**, that I last saw the deceased alive on **6/6, 1958**, and that death occurred at **4:30 p.m.**, from the causes and on the date stated above.

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|-----------------------------------------------------------|--|-----------------------------------------------------------------------------|--|-------------------------------------------------------------------|--|
| 23a. SIGNATURE J. L. Spence M.D. (Degree or title) | | 23b. ADDRESS Carool, Mo | | 23c. DATE SIGNED 6/9/58 | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 24b. DATE 6-9-58 | | 24c. NAME OF CEMETERY OR CREMATORY CABOOL CEM. CAROOL, MO. | |
| 24d. LOCATION (City, town, or county) (State) | | 25. FUNERAL DIRECTOR'S SIGNATURE Elliot - Newby, Carool, Mo. ADDRESS | | | |
| DATE REC'D BY LOCAL REG. 6-9-58 | | REGISTRAR'S SIGNATURE Gaynell Cunningham | | | |

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

325

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

James L. Gentry

Licensed Embalmer No. _____

14718

P. O. Address _____

Calrod, Mo.

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.