MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County: Cooper

Township or Village or City: Palestine

Registration District No.: 219 — File No.: 2 42033

Primary Registration District No.: 5301 — Registered No.: 192

(NO. ____, ____ St.; ____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME: Alex Howey Drew

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: Black

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): ✓

DATE OF BIRTH: Mar 24 (Month) (Day), 1920 (Year)

AGE: ____ yrs. ____ mos. 3 ds.

If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: ✓
(b) General nature of industry, business, or establishment in which employed (or employer): ✓

BIRTHPLACE (City or town, State or foreign country): Cooper Co Mo

PARENTS

NAME OF FATHER: Ed Drew

BIRTHPLACE OF FATHER (City or town, State or foreign country): Cooper Co

MAIDEN NAME OF MOTHER: Margaret Smith

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Cooper Co

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): Ed Drew

(ADDRESS): Speed Mo

Filed 4-10, 1920. C. B. Shrout, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: 3/27 (Month) (Day), 1920 (Year)

I HEREBY CERTIFY, that I attended deceased from ✓, 191__, to ✓, 191__, that I last saw him alive on Mar 24, 1920, and that death occurred, on the date stated above, at ____ m.

The CAUSE OF DEATH* was as follows:

Congenital Debility

158 150

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory (SECONDARY) ____

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) E. M. Albee M. D.

3/27, 1920 (Address) Speed Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury: and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death? ____

Former or usual residence ____

PLACE OF BURIAL OR REMOVAL: Speed

DATE OF BURIAL: May 28, 1920

UNDERTAKER: J. Wilson

ADDRESS: Bunceton Mo

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

County _____

Township _____ Registration District No. _____ File No. _____

or

Village _____ Primary Registration District No. _____ Registered No. _____

or

City _____ (NO. _____, _____ St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

_____ (Month) _____ (Day), 1 (Year)

AGE _____ yrs. _____ mos. _____ ds.

If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191__, _____

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

_____ (Month) _____ (Day), 191__ (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191__, to _____, 191__, that I last saw h_____ alive on _____, 191__, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

_____

_____

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory _____
(SECONDARY)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

_____, 191__ (Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	_____, 191__
UNDERTAKER	ADDRESS