LOCAL REGISTRAR'S REPORT — DO NOT TEAR THIS OUT

FEB 30

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

3727

1. PLACE OF DEATH

County: Shelby — Registration District No.: 830 — File No.: 6

Township: Salt River — Primary Registration District No.: 6091 — Registered No.:

City: Shelbina (No. ..., ..., St. ..., Ward)

2. FULL NAME Charles Edward Drawo

(a) ~~Residence~~ (Usual place of abode) No. Funnel Hospital St., Ward. (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Married

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Etta Drawo

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 2, 1864

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	65	2	18	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired farmer

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

(c) Name of employer:

9. BIRTHPLACE (CITY OR TOWN) Warsaw (STATE OR COUNTRY) Ill.

PARENTS

10. NAME OF FATHER Samuel Drawo

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Penn.

12. MAIDEN NAME OF MOTHER Frances Dobler

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Penn.

14. INFORMANT Mrs. Etta Drawo (Address) Shelbina, Mo.

15. Filed Feb 15, 1930 Madge Yooch Registrar

MEDICAL CERTIFICATE OF DEATH

2

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 20 - 1930

17. I HEREBY CERTIFY, That I attended deceased from Jan 15, 1930, to Jan 20, 1930 that I last saw him alive on Jan 20, 1930, and that death occurred, on the date stated above, at 3:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Peritonitis

17-2 B.

1-2 B.

1-3 B.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (SECONDARY) Intestinal obstruction with perforation (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? yes DATE OF Jan 19-30

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical & Laboratory

(Signed) C. C. Thomson, M. D.

, 19 (Address) Shelbina Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Traer, Iowa	Jan 24 1930

20. UNDERTAKER	ADDRESS
J. W. Thompson Son	Shelbyville

LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

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

1. PLACE OF DEATH.

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No....., ...St. .....Ward)

2. FULL NAME .....

(a) Residence. No..... St., ...Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

14.
INFORMANT .....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17.
I HEREBY CERTIFY, That I attended deceased from .....
....., 19....., to ....., 19.....
that I last saw h..... alive on....., 19....., 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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL | DATE OF BURIAL

20. UNDERTAKER | ADDRESS

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
County: Shelby — Registration District No.: 820 — File No.:
Township: Salt River — Primary Registration District No.: 6091 — Registered No.: 6
City: (No. St. Ward)

2. FULL NAME: Charles Edward Dravo

(a) Residence. No. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): M

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE — YEARS — MONTHS — DAYS — If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14. INFORMANT
(Address)

15. FILED Feb 15 30 19 Madge Gooch REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 20 1930

17. I HEREBY CERTIFY, That I attended deceased from 19, to 19, that I last saw h. alive on 19, and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Peritonitis due to gangrene of bowels
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Intestinal Obstruction with perforation
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL — DATE OF BURIAL 19

20. UNDERTAKER — ADDRESS

SUPPLEMENTARY

—Every item of information should be carefully supplied. AGE should be stated [illegible] PHYSICIANS [illegible] OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

TRANS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE [illegible] AS PRESCRIBED [illegible] LAW

S-3229