

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

**PLACE OF DEATH**

County Greene

Township \_\_\_\_\_ or Village \_\_\_\_\_

Registration District No. 318

File No. 41144

City Springfield

Primary Registration District No. 2001

Registered No. 727

(NO. 430 South Grant St. 2<sup>nd</sup> Ward)

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

**FULL NAME** Lilburn H. Murray

**PERSONAL AND STATISTICAL PARTICULARS**

SEX Male COLOR OR RACE White SINGLE MARRIED Widower WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH Sept 15<sup>th</sup> 1835  
(Month) (Day) (Year)

AGE 76 yrs. 3 mos. 1 ds. IF LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.?

OCCUPATION (a) Trade, profession, or particular kind of work Banker & Merchant  
(b) General nature of industry, business, or establishment in which employed (or employer) W-03

BIRTHPLACE Crawford Co. Mo.  
(City or town, State or foreign country)

**PARENTS**  
NAME OF FATHER John Murray  
BIRTHPLACE OF FATHER Virginia  
(City or town, State or foreign country)  
MAIDEN NAME OF MOTHER Sarah Luttrell  
BIRTHPLACE OF MOTHER Mo.  
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Bea Murray  
(ADDRESS) 430 S. Grant St.

Filed 12-18 1911 4th REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH Dec 16<sup>th</sup> 1911  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 15<sup>th</sup> 1911, to Dec 16<sup>th</sup> 1911, that I last saw him alive on Dec 16<sup>th</sup> 1911, and that death occurred, on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH\* was as follows:  
Uraemia  
131  
110 E  
Duration 13 yrs. 0 mos. 20 ds.

Contributory Pleurisy with Effusion  
(SECONDARY) Duration 3 yrs. 0 mos. 0 ds.

(Signed) W. P. Patterson M. D.  
Dec 15<sup>th</sup> 1911 (Address) Springfield 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 Maple Park DATE OF BURIAL 12-18 1911

UNDERTAKER Paxson & Co ADDRESS 410 South

# Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health Association]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sar-*

*coma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)



MISSOURI STATE BOARD OF HEALTH

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

Patterson

PLACE OF DEATH  
County Greene  
Township \_\_\_\_\_  
or \_\_\_\_\_  
Village \_\_\_\_\_  
or \_\_\_\_\_  
City Spfld (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 318 File No. 41144  
Primary Registration District No. 2001 Registered No. 727

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

FULL NAME Zilburn H Murray

PERSONAL AND STATISTICAL PARTICULARS

SEX M COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED W  
(Write the word)  
DATE OF BIRTH 9/15 1885  
(Month) (Day) (Year)  
AGE 26 yrs. 3 mos. 1 ds.  
If LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 12/16, 1911  
(Month) (Day) (Year)  
I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 1911, to 9/16, 1911, that I last saw him alive on 11/16, 1911, and that death occurred, on the date stated above, at 4:30 p.m.  
The CAUSE OF DEATH\* was as follows:

OCCUPATION  
(a) Trade, profession, or particular kind of work Traveller & merchant  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

Chronic nephritis X

BIRTHPLACE (City or town, State or foreign country) Mo. Va.  
NAME OF FATHER Jno Murray  
BIRTHPLACE OF FATHER (City or town, State or foreign country) Mo. Va.  
MAIDEN NAME OF MOTHER Sarah Luttrell  
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Leun.

Contributory Chronic uremia  
(SECONDARY)  
(Duration) \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.  
(Signed) W. P. Patterson M. D.  
2/18 1912 (Address) Springfield

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo Murray  
(ADDRESS) 430 S. Grant  
Filed 2/18 1912 J. B. Jimmon REGISTRAR

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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 Maple Park DATE OF BURIAL 12-18 1911  
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