

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

Do not use this space.

36864

1. PLACE OF DEATH

County Greene

Registration District No. 318

Township Springfield

Primary Registration District No. 2333 Ramsey

City Springfield

File No.

Registered No. 796

St. Ward)

2. FULL NAME

(a) Residence. No. 2333 Ramsey 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED OR DIVORCED HUSBAND OR (or) WIFE of Lizzie M. Murry

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 23-1857

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
70 10 0

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

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

10. NAME OF FATHER Pastor M. Murry

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Mrs. Lizzie M. Murry
(Address) Springfield, Mo.

15. FILED 12/24/27 REGISTRAR Oct Forest Mbs

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 23 1927

17. I HEREBY CERTIFY, That I attended deceased from Dec 22, 1927, to Dec 23, 1927 that I last saw him alive on Dec 23, 1927, and that death occurred, on the date stated above, at 1:30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Paralysis
827
827 (duration) yrs. mos. 1/2 da.

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. da.

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

19. DID AN OPERATION PRECEDE DEATH? no. DATE OF.....

20. WAS THERE AN AUTOPSY? no.

WHAT TEST CONFIRMED DIAGNOSIS?.....
(Signed) J. S. Tilling, M. D.
Dec 23, 1927 (Address) Greenefield Mo

*State the DISEASE CAUSING DEATH, or 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 Green Lawn Cemetery DATE OF BURIAL Dec 24 1927

20. UNDERTAKER J. W. Higgins ADDRESS P. O. 424 6th St, Springfield, Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1. **Organization:** The organization of the Army is based on the principle of unity of command. The Chief of Staff is the principal staff officer of the Army and is responsible for the coordination and control of the Army's operations. The Chief of Staff is assisted by the Deputy Chief of Staff, who is responsible for the day-to-day operations of the Army. The Chief of Staff is also responsible for the preparation and submission of the Army's budget and for the management of the Army's personnel and resources.

2. **Functions:** The functions of the Chief of Staff are to advise the Secretary of Defense on all matters relating to the Army, to coordinate the activities of the Army's various agencies, and to ensure that the Army is prepared to meet its obligations to the Nation. The Chief of Staff is also responsible for the development and implementation of the Army's strategic and tactical plans, and for the management of the Army's operations.

3. **Structure:** The structure of the Army is based on the principle of unity of command. The Chief of Staff is the principal staff officer of the Army and is responsible for the coordination and control of the Army's operations. The Chief of Staff is assisted by the Deputy Chief of Staff, who is responsible for the day-to-day operations of the Army. The Chief of Staff is also responsible for the preparation and submission of the Army's budget and for the management of the Army's personnel and resources.

4. **Personnel:** The personnel of the Army are organized into various agencies, each of which is responsible for a specific function. The agencies are organized into a hierarchy, with the Chief of Staff at the top and various staff officers and personnel below. The personnel of the Army are trained and equipped to perform their duties in a professional and efficient manner.

5. **Resources:** The resources of the Army are managed by the Chief of Staff and the Deputy Chief of Staff. The resources include personnel, equipment, and funds. The Chief of Staff is responsible for ensuring that the Army's resources are used in the most effective and efficient manner possible.

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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Buene Registration District No. 318 File No. _____
Township _____ Primary Registration District No. 2001 Registered No. 796
City Springfield (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 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)

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. 12/24/27 Octorist me
FILED 19 _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 23 19 27

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:

Paralysis due to Hemiplegia & Apoplexy

CONTRIBUTORY (SECONDARY)

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

SUPPLEMENTARY

N. B.—Every REGISTRAR SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

10-15-64