

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

Do not use this space.

1. PLACE OF DEATH

County Greene
Township Center
City Asht Grove

Registration District No. 320
Primary Registration District No. 5443
(No. Base Line Pte 1)

File No. 8591
Registered No. _____
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. Bois d Arc Pte 1 St. _____ Ward. _____
(Usual place of abode)

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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 25 / 1861

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 67 0- 12 24 11

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

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

10. NAME OF FATHER Harvey Murray

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

12. MAIDEN NAME OF MOTHER Jane Patton

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

14. INFORMANT D. J. Starkey
(Address) Rt 2 Ash Grove Mo

15. FILED 3/10, 19 28 Larry E. Hoyd REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/8 19 28

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:

3411
1928 Influenza Pectoris
30 Inflammation Kidney
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? clinical
(Signed) Jewell C. Waddle coroner
3/11 1928 (Address) Springfield 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 Wm Prop Cemetery DATE OF BURIAL 3/10 19 28

20. UNDERTAKER W. L. Larrault ADDRESS Asht Grove Mo

N. B.—Exact 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.

etate blucda SHADISYH
HOI

QANK beJa e
statement

EGA
teffhaale chzoqog ed

on
en

Y.N.
IAC

**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 Greene

Registration District No. 320

File No. 7

Township Center

Primary Registration District No. 3443

Registered No. _____

City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

William R. Murray

(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. da. How long in U.S., if of foreign birth? yrs. mos. da.

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 OR (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)

FILED 3-10-28 Lucy Hoyal
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-8-1928

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Angina pectoris
Acute Nephritis

CONTRIBUTORY (SECONDARY) Inflammation Kidney

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH

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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

19

N. I. Every item of information should be stated EXACTLY. PHYSICIANS should be properly classified. Exact statement of OCCUPATION is very important.

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

SUPPLEMENTARY

1658-5