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.

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

1 PLACE OF DEATH

County St Clair

Township Jackson
or
Village
or
City (NO. St.; Ward)

Registration District No. 1037 File No. 22811

Primary Registration District No. 6012 Registered No.

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

2 FULL NAME Henry Greene Murray

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married

6 DATE OF BIRTH (Month) (Day) 1 (Year)

7 AGE 62 yrs. 9 mos. 9 ds. If LESS than 1 day, hrs. or min.?

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

9 BIRTHPLACE (City or town, State or foreign country) Missouri

PARENTS

10 NAME OF FATHER John W Murray

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

12 MAIDEN NAME OF MOTHER Rachel Lukheares

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lizzie Murray
(Address) Iconium Mo.

15 Filed 7 8 1938 Mon W F Hudson Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 21 1938 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from June 21 1938, to June 21 1938, that I last saw him alive on June 21 1938, and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorage.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Leo Sheldon Wright M. D.

191 (Address) Sowry City Mo

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

18 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

19 PLACE OF BURIAL OR REMOVAL Iconium Mo. DATE OF BURIAL June 22 1938

20 UNDERTAKER J R Lukey ADDRESS Wheatland Mo

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

1 PLACE 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.]

2 FULL NAME .....

N. B.—Every item of information should be carefully supplied. AGE should be stated: EXACTLY in infants. CAUSE OF DEATH should be stated in plain terms, so that it may be properly classified. Exact statement of [illegible] IMPORTANCE

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH
..... (Month) ..... (Day) ....., 1..... (Year)

7 AGE
.....yrs.....mos.....ds.

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

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

9 BIRTHPLACE
(City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

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

12 MAIDEN NAME OF MOTHER

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
....., 191.....
(Month) (Day) (Year)

17 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.

18 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 .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	....., 191.....
20 UNDERTAKER	**ADDRESS**

REC'D JUL 11 1938

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

S-22811

Do not use this space.

1. PLACE OF DEATH
(a) County St Clair — Registration District No. 1037
(b) Township Oak — Primary Registration District No. 6017 — Registered No.
(c) City Iconium — (d) Street No. ..... St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Harvey Green Murray 600
(a) Residence, No. ..... St. ☐ (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: wht
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Lizzie Murray
6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Sept 12, 1875
7. AGE: YEARS 62 — MONTHS 9 — DAYS 9 — If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc.: Farmer
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Missouri

FATHER
13. NAME: John W Murray
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Missouri

MOTHER
15. MAIDEN NAME: Rachel Breshear's
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Missouri

17. INFORMANT (ADDRESS): Lizzie Murray, Iconium Mo
18. BURIAL, CREMATION, OR REMOVAL — PLACE Iconium — DATE 6/22, 1938
19. FUNERAL DIRECTOR (NAME) J R Luckey (ADDRESS) Wheatland, Mo
20. FILED 7 7, 1938 Mrs W F Hudson, Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): June 21, 1938
22. I HEREBY CERTIFY, That I attended deceased from June 21st, 1938, to June 21st, 1938
I last saw him alive on June 21st, 1938. Death is said to have occurred on the date stated above, at 9:00 a m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebral Hemorrhage	Sudden
SUPPLEMENT	
Other contributory causes of importance:	
Hypertension	1/1/34
Arteriosclerosis	1/1/34

Name of operation ✓ Date of
What test confirmed diagnosis? ✓ Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ✓ Date of injury ✓, 19
Where did injury occur? ✓
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury ✓
Nature of injury ✓

24. Was disease of injury in any way related to occupation of deceased? No
If so, specify
(Signed) Leo Sheldon Wright, M. D.
694 (Address) Lowry City, Mo

(Licensed Embalmer's Statement on Reverse Side)

NUMBER of 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.

S-22811

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, J R Lucky, or by .....

Registered Apprentice No....., working under my personal supervision.

Signed J R Lucky

Licensed Embalmer No. 298

P. O. Address Wheatland

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.