

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

24253

1. PLACE OF DEATH
 County Henry Registration District No. 355
 Township Barrow Primary Registration District No. 5497
 City Barrow, Mo. St. Mo. Ward 0

2. FULL NAME Herb P. Murall
 (a) Residence, No. Barrow, Mo. St. Mo. Ward 0
 (Usual place of abode)
 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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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 Luella A. Murall
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 19, 1863
 7. AGE YEARS 71 MONTHS r DAYS 0 IF LESS than 1 day, hrs. or min.
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Farmer (Retired)
 (b) General nature of industry, business, or establishment in which employed (or employer) r
 (c) Name of employer Wilton Davis
 9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Muscataine Mo
 10. NAME OF FATHER Peter Murall
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Bever, Ark
 12. MAIDEN NAME OF MOTHER Clivia Kerpmanis
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Bever, Ark
 14. INFORMANT Luella Mitchell
 (Address) Barrow, Mo.
 15. FILED 8-10-34 WE Baggerly
 REGISTRAR

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 5th 1934
 17. I HEREBY CERTIFY, That I deceased deceased
 that I last saw him alive July 5th 1934 and that death occurred, on the date stated above, at about 9 a.m.
 THE CAUSE OF DEATH WAS AS FOLLOWS
Accidental discharge of
bullet carried that day
in his own hands while
working. Shot through the
heart.
 CONTRIBUTORY (SECONDARY) 1874
 18. WHERE WAS DISEASE CONTRACTED 1874
 IF NOT AT PLACE OF DEATH. 1874
 19. DID AN OPERATION PRECEDE DEATH? No DATE OF
 WAS THERE AN AUTOPSY? No
 WHAT TEST CONFIRMED DIAGNOSIS? W. J. Speer
 (Signed) Clinton, 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. (See reverse side for additional space.) Accidental
 19. PLACE OF BURIAL, CREMATION, OR REMOVAL Barrow Mo DATE OF BURIAL 7/10/34
 20. UNDERTAKER J. Lennartz ADDRESS Montrose 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. AUG 24 1934

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, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasm); *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," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.); "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "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.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them: Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

#2 *Henry*

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
WASHINGTON

E. T. McGaugh, M. D.,
Special Agent,
Jefferson City, Mo.
5 -

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: *Fred P Muralf*
Who died at _____ on *July - 5 - 1934*
Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____
Sex _____ Color or race _____ Single, married, widowed or divorced: _____

Date of birth *Oct. 19, 1863* Age: Years *70* Months *7* Days *5*

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____
(b) Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____

Date deceased last worked at this occupation: Month _____ Year _____
Birthplace (State or country) _____
Birthplace of father (State or country) _____
Birthplace of mother (State or country) _____
Principal cause of death: _____

Other contributory causes of importance _____
Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____
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 _____
Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
Name of physician _____
Address of physician _____

Signature of Registrar *X W E P O g g e r l y n d* Date filed *8-10-34*

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Reg. Dist. No. *355 -* Very truly yours,
Primary Reg. Dist. No. *5497* *E. T. McGaugh, M.D.*
Special Agent. *K.*

SECRET #8600

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