

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

Do not use this space.

4836

1. PLACE OF DEATH

County Jackson
Township Law
City Kansas City (No. Trinity Lutheran Hosp. Ward)

Registration District No. 399
Ephery Registration District No. 1002

File No. 439
Registered No. 439

2. FULL NAME

Mrs. Ruth Rutherford
(a) Residence. No. 105 E. 78th Terrace Ward. 6
(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 Female 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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 5. 1897

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
34 | 11 | 28

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

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

10. NAME OF FATHER Wm A. Guffin

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

12. MAIDEN NAME OF MOTHER Tabitha Brown

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

14. INFORMANT (Address) Frank R. Rutherford
105 E 78th Terr

15. FILED 4/3 28 M. M. Levine REGISTRAR
Assn

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from Jan. 18 1928 to Feb. 3 1928 that I last saw her alive on Feb. 3 1928 and that death occurred, on the date stated above at 11 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
1228 Intestinal Obstruction
129 (Partial, becoming complete (duration) 6 da.
CONTRIBUTORY General Peritonitis
(SECONDARY) (duration) 5 da.

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

DID AN OPERATION PRECEDE DEATH? Yes DATE Jan 19/28

19. WAS THERE AN AUTOPSY? Operation Feb 1/28

WHAT TEST CONFIRMED DIAGNOSIS? Operation
(Signed) John H. O'Neil M. D.
Address 1002 Argyle

*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.

20. PLACE OF BURIAL, CREMATION, OR REMOVAL Forest Hill DATE OF BURIAL 2-6-28

20. UNDERTAKER H. H. Newcome ADDRESS 1002 Argyle

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.

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1-4-

X

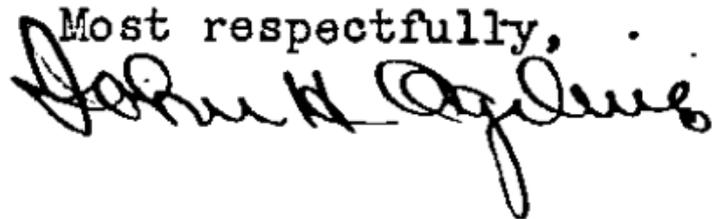
Ruth Rutherford

Concerning the death of Ruth Rutherford -
the sequence of events was as follows:

1. Acute general peritonitis
2. Adhesions
3. Intestinal obstruction (Acute)
4. Death

I have no further information to give you
in these cases. These are the actual facts.

Most respectfully,



JHO.S

(S) 4836

**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.
 County Jackson Registration District No. 299 File No.
 Township Primary Registration District No. 1022 Registered No. 489
 City W.C. (No.) St. Ward

2. FULL NAME Ruth Rutherford
 (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 F 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) 2-5-1893

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. FILED 7/3 1928 M.M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-3 19 28

17. I HEREBY CERTIFY, That I attended deceased from 19....., to 19....., (that I last saw b., care of 19....., and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Intestinal obstruction
Partial becoming complete
General peritonitis
 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 118 B 2
 (duration) yrs. mos. ds.

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

Applied. AGE should be stated EXACTLY. PHYSICIANS should state properly classified. Exact statement of OCCUPATION is very important. REGISTRARS REGISTERED UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

9284(2)S