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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

23348

FILED AUG 7 1946

State File No. _____

Registration District No. 127

Primary Registration District No. 2464

Registrar's No. 6

1. PLACE OF DEATH:

(a) County Greene

(b) City or town Springfield, Mo R6
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Rural Murray Township
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution None
(Specify whether years, months or days)

In this community 2 months

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 39

(c) City or town Springfield, Mo R 6
(If outside city or town limits, write "RURAL") 5

(d) Street No. _____
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Frances Elizabeth Rutherford

3. (b) If veteran, name war Nil 3. (c) Social Security No. Nil

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced, widowed

6. (b) Name of husband or wife John Owens Rutherford 6. (c) Age of husband, or wife if alive deceased

7. Birth date of deceased May 20th 1866
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

80 1 22 hr. min.

9. Birthplace Barton County Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business Home

12. Name Jesse Patty Rutherford

13. Birthplace Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Mary Oneal

15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant George Sheridan Rutherford

(b) Address Springfield, Mo R 6

17. (a) Burial (b) Date thereof 7 - 13 - 46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation McCune Kansas

18. (a) Signature of funeral director Gene A. Brown

(b) Address Walnut Grove, Missouri

19. (a) 7-12-46 (b) Jane Appleby
(Date received local registrar) (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 12th
year 1946 hour 2 minute 8 A.M.

21. I hereby certify that I attended the deceased from June 4, 1946, 19... to July 12th, 1946
that I last saw her alive on July 11th, 1946, 19...
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac decompensation
and ultimate failure from old mitral
lesion. Also several previous

Due to cerebral hemorrhages resulting
in paralysis of the left side of her
body. Also contributing cause
was sinility.

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations NONE 430

Of autopsy _____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? _____
(Specify type of place) (Specify means of injury)

23. Signature [Signature] (M. D. or other) _____
Address [Address] Date signed 7/12/46

WRITE PLAINLY—USE UNFADING, BLACK INK—MAKE A PERMANENT RECORD

110

RECEIVED

Greene County Health Office,

County File Number 46-8-93

Date Filed 8-5-46

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

Signed.....

Clair D. Noblett

Licensed Embalmer No. 4005

P. O. Address Call Flow, Mo.

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

If this body is not embalmed, fact should be so stated above.

Registration District No. 127

Primary Registration District No. 5464

1. PLACE OF DEATH:

(a) County Shrew

(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Frances E. Rutherford

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month _____
year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

4. Sex F

5. Color or race w

6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if _____

7. Birth date of deceased: may (Month) _____ (Day) _____ (Year) _____

8. AGE: Years 80 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____
(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) _____ (b) Jane Appleby
(Date received local registrar) (Registrar's signature)

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:
Of operations _____

Of autopsy _____

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
(c) Means of injury _____

23. Signature _____ (M. D. or other) _____
Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

23348