

No. 300  
M-10-47  
7-5-17-39  
I 3906

FEDERAL BUREAU OF VITAL STATISTICS  
National Office of Vital Statistics  
FILED MAY 7 1948  
MISSOURI DEPARTMENT OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 14609  
3897  
Registrar's No. 1003

Registration District No. 318 Primary Registration District No. 1003

1. PLACE OF DEATH:  
(a) County.....  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Louis City Hospital 0  
(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 Missouri (b) County.....  
(c) City or town St. Louis 17  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4916 Laclede Ave. 9  
(If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No) 0  
If yes, name country.....

3. (a) PRINT FULL NAME James Franklin Rutherford  
3. (b) If veteran, name war No  
3. (c) Social Security No. Unknown  
4. Sex Male 0 5. Color or race White  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Lottie Rutherford  
6. (c) Age of husband or wife if alive 46 years  
7. Birth date of deceased July 30 1875  
(Month) (Day) (Year)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month April day 24  
year 1948 hour 12:30 minute A M.  
21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....;  
that I last saw him alive on....., 19.....;  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
72 8 24 hr. min.

Immediate cause of death Lobar Pneumonia Duration  
108

9. Birthplace Grays Summit Missouri (City, town, or county) (State or foreign country)  
10. Usual occupation Electrician

Due to.....  
Due to.....  
Other conditions (Include pregnancy within 3 months of death)  
Major findings:  
Of operations.....  
Of autopsy.....  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

11. Industry or business.....  
MOTHER FATHER { 12. Name Unknown 0  
13. Birthplace Unknown (City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Lottie Rutherford  
(b) Address 4916 Laclede Ave.  
17. (a) Burial (b) Date thereof 4-26-47  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Memorial Park Cemetery

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?

18. (a) Signature of funeral director Albert H. Hoppe  
(b) Address 4700 W. Washington Blvd.  
19. (a) APR 23 1948 (b) J. F. Bredick  
(Date of registration) (Registrar's signature)

While at work? (Specify type of place) (c) Means of injury.....  
23. Signature Dr. Alfred J. Ferris M.D. or other  
Address Dr. Ferris Date signed 4/25/48

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

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**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 <sup>4/1</sup> <sub>2061</sub> under my personal supervision.

Signed Oliver R. Cadwell

Licensed Embalmer No. 42077

P. O. Address.....

**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.**