

**FILED** NOV 13 1945  
128

Primary Registration District No. 5000

Registrar's No. 885

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

1. PLACE OF DEATH:

(a) County Greene  
(b) City or town Springfield  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
809 Garfield  
(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 Greene 39  
(c) City or town Springfield 7  
(If outside city or town limits, write "RURAL") 6  
(d) Street No. 809 Garfield  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Bitha Elizabeth Henson Blair

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Eddie Blair 6. (c) Age of husband or wife if alive UNK years  
7. Birth date of deceased July 4 1891  
(Month) (Day) (Year)

8. AGE: Years 54 Months 3 Days 25 If less than one day  
hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Housewife

11. Industry or business In Home

MOTHER { 12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Mrs Claudine Newell  
(b) Address Stoutland, Mo.

17. (a) Burial (b) Date thereof NOV 2 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Richland, Mo.

18. (a) Signature of funeral director J.W. Klingner & Co.  
(b) Address Springfield Mo.

19. (a) 11-1-45 (b) S. W. Handley  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 29  
year 1945 hour 8:30 minute P M.

21. I hereby certify that I attended the deceased from 9-15-1945 to 10-29-1945  
that I last saw him alive on 10-29-1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Cancer - SPEECH  
Duration Un- Known

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy 55x

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? \_\_\_\_\_

(Specify type of place) \_\_\_\_\_ While at work? (Specify type of place) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature J. J. Jamsiek (M. D. or other) \_\_\_\_\_

Address Springfield, Mo. Date signed 10-29-45

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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 under my personal supervision.

Signed.....

Licensed Embalmer No.....

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.**

X