

S. No. 2  
M-5-43  
7-5-17-39  
I X36671

**FILED** NOV 28 1945  
Registration District No. 128

Primary Registration District No. 2000

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: Mary E. Wilson Home 4  
(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 2  
(If outside city or town limits, write "RURAL")  
(d) Street No. Mary E. Wilson Home - 924 N. Main  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME ADA L. BLYTHE

3. (b) If veteran, name war NONE 3. (c) Social Security No. NONE

4. Sex Female / 5. Color or race White  
6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife J. M. Blythe  
6. (c) Age of husband or wife if alive Deo. years  
7. Birth date of deceased November 14, 1858  
(Month) (Day) (Year)

8. AGE: Years 86 Months 11 Days 29  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Covington, Kentucky 1  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name Tom Comstock  
13. Birthplace Unknown New York 1  
(City, town, or county) (State or foreign country)  
14. Maiden name Margaret Watson  
15. Birthplace Unknown Pennsylvania 1  
(City, town, or county) (State or foreign country)

16. (a) Informant William H. Blythe  
(b) Address Golden Edge, New York.

17. (a) Removal (b) Date thereof 11/2/1945  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Crown Hill Cemetery

18. (a) Signature of funeral director Alma Lohmeyer Funeral Home  
(b) Address 534 St. Louis Street

19. (a) 11-2-45 (b) W. W. Handley  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 1,  
year 1945 hour 2: minute 00 P.M.

21. I hereby certify that I attended the deceased from Oct 14, 1945, to Nov 1, 1945.  
that I last saw her alive on Nov 1 and that death occurred on the date and hour stated above.  
Immediate cause of death Heart failure Duration \_\_\_\_\_

Due to Chronic Myocarditis 4 years  
Genus of Debility

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.

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? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature W. W. Handley (M. D. or other) \_\_\_\_\_  
Address 324 S. Main Bldg Date signed 11/2/45  
Spd, Ma.

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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..... *C. A. Paul*.....

Licensed Embalmer No. *3248*.....

P. O. Address *Springfield 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.**