

FILED APR 28 1944
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MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

14653

State File No. _____

Registration District No. _____

Primary Registration District No. 2000

Registrar's No. 330

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:
802 S. Kickapoo
(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

3. (a) PRINT FULL NAME James T. Blair

3. (b) If veteran, name war No.

3. (c) Social Security No. No.

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Grace Blair

6. (c) Age of husband or wife if alive unk years

7. Birth date of deceased. Nov. 11, 1871
(Month) (Day) (Year)

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

72 5 1 hr. min.

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

10. Usual occupation Retired

11. Industry or business _____

MOTHER FATHER { 12. Name Dr. Samuel Tate Blair

{ 13. Birthplace Lowden Tennessee
(City, town, or county) (State or foreign country)

{ 14. Maiden name Louisan Osborne

{ 15. Birthplace Philadelphia Tennessee
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Grace Blair

(b) Address Jefferson City, Mo.

17. (a) Burial (b) Date thereof April 14, 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Jefferson City, Mo.

18. (a) Signature of funeral director H.H. Lohmeyer

(b) Address Springfield, Mo.

19. (a) 4-14-44 (b) H. Handley
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cole 26

(c) City or town Jefferson City
(If outside city or town limits, write "RURAL") 5

(d) Street No. 915 Fairmont
(If rural, give location) 4

(e) Citizen of foreign country? / (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 12
year 1944 hour 3 minute 30 p.m.

21. I hereby certify that I attended the deceased from Feb 1, 1944 to April 12, 1944
that I last saw him alive on April 12, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic nephritis

Due to _____

Due to _____

Other conditions Chronic Nephritis
(Include pregnancy within 3 months of death)
deceased

Major findings: Of operations _____

Of autopsy 131

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) (Means of injury)

23. Signature W. A. DeLoe (M. D. or other) M.D.

Address Springfield Date signed 4/14/44

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

9
2
6

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 *L. D. Edwin Gorman*

Licensed Embalmer No. *3177*

P. O. Address *Springfield*

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.