

JAN 12 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 41599

Registrar's No. 10722

Registration District No. 791

Primary Registration District No. _____

1. PLACE OF DEATH: ICU 3

(a) County 1

(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Mo. Baptist Hospital
(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 Robert Earl Blaylock 442

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Edna 6. (c) Age of husband or wife if alive 48 years

7. Birth date of deceased June 8 1891
(Month) (Day) (Year)

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

48 6 7 hr. _____ min.

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

10. Usual occupation Executive

11. Industry or business County Life Ins. Co.

12. Name William Blaylock

18. Birthplace Asheville, N. Carolina
(City, town, or county) (State or foreign country)

14. Maiden name Lucy Ann Burrows

15. Birthplace Chapel Hill N. Carolina
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Edna Blaylock

(b) Address Anna, Ill.

17. (a) Removal (b) Date thereof 12/16/39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Anna, Ill.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 2700 Washington Ave.

19. (a) DEC 15 1939 (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 2

(a) State Illinois (b) County _____

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

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

(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 15
year 1939 hour 4 minute 30 A. M.

21. I hereby certify that I attended the deceased from 7-11-39
_____, 19____, to 12-15-39, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Typhoid-Paratyphoid
Septicemic Typhoid
Glands

Due to _____

Due to _____

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

Major findings: _____
Of operations _____

Of autopsy _____

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) (e) Means of injury _____

23. Signature RK Anderson (M. D. or other) _____

Address 4452 W. Main St. Date signed 12/15/39

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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 *Albert G. Koffa*

Licensed Embalmer No. *2971*

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, above space should be left blank.