

AMENDED

Registration District No. **318** Primary Registration District **1003** Registrar's No. **9849** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		a. STATE Illinois b. COUNTY Madison	Length of stay in 1b 3 weeks
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Firmin Desloge		c. CITY OR TOWN Granite City	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
		d. STREET ADDRESS 5036 Lake View Dr.	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last HAROLD G. BLAYLOCK			4. DATE OF DEATH Month Day Year Oct. 22, 1961	
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10-4-02	9. AGE (last birthday) 59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Exterminator		10b. KIND OF BUSINESS OR INDUSTRY Pest Control	11. BIRTHPLACE (City and state or country) Perryville, Mo.	12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME Thomas I. Blaylock		13b. MOTHER'S MAIDEN NAME Alice Deck		14. NAME OF HUSBAND OR WIFE Iva G. Blaylock

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No

17. INFORMANT Address
Charles G. Blaylock, City, Ill

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)	AORTA to ESOPHAGUS - FISTULA	INTERVAL BETWEEN ONSET AND DEATH 5 min.
DOE TO (b)	FAILURE OF HEALING OF ESOPHAGO-GASTROSTOMY	1 week
DOE TO (c)	CARCINOMA ESOPHAGUS.	3 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
150X

PART III. If deceased was female was there a pregnancy in last 90 days.
 Yes N- Unknown

19. WAS AUTOPSY PERFORMED? YES NO

20a. ACCIDENT SUICIDE HOMICIDE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour Month, Day, Year
a.m. p.m.

20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from **Sept. 29, 1961** to **Oct. 22, 1961** and last saw her alive on **Oct 22, 1961**
Death occurred at **7:45 A. M.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title)
C. Rollins Houlton M.D.

22b. ADDRESS
1325 S. GRAND BLVD ST. LOUIS 4

22c. DATE SIGNED
10/24/61

23a. BURIAL, CREMATION, REMOVAL (Specify)
Removal

23b. DATE
10/25/61

23c. NAME OF CEMETERY OR CREMATORY
Lake View Memo Gardens

23d. LOCATION (City, town, or county)
Belleville, Ill.

24. FUNERAL DIRECTOR ADDRESS
Sedlack Bros. E. St. Louis, Ill.

25. DATE REG. BY LOCAL REG.
OCT 25 1961

26. REGISTRAR'S SIGNATURE
Earl Smith, M.D.

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

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 NOT EMBALMED, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Sedlack Bros. Funeral Home

Signed _____
East St. Louis, Ill.
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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.