

FILED MAY 10 1945 STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 5

Primary Registration District No. 3009

Registrar's No. 13

1. PLACE OF DEATH:

(a) County Cape Girardeau

(b) City or town Jackson
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Greensferry
(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 Cape Girardeau

(c) City or town Jackson 16
(If outside city or town limits, write "RURAL")

(d) Street No. Greensferry 2
(If rural, give location)

(e) Citizen of foreign country? NO 1 (Yes or No)

If yes, name country.....

3. (a) PRINT FULL NAME William Franklin Blaylock

(b) If veteran, name war.....

(c) Social Security No.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 8th
year 1945 hour 9 minute 30 pm

4. Sex M D 5. Color or race W

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

(b) Name of husband or wife Mary E Blaylock

(c) Age of husband or wife if alive 72 years

7. Birth date of deceased August 17, 1871
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from April 3rd, 1945, to April 8th, 1945;
that I last saw him alive on April 8th, 1945;
and that death occurred on the date and hour stated above.

8. AGE: Years 73 Months 7 Days 21
If less than one day hr. min.

Immediate cause of death Cardiac De-compensation (Congestive Heart Failure)

Due to Compensatory Nephrosis (Uremia)

Due to.....

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

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

10. Usual occupation Farmer

Major findings: HEAL
Of operations..... HEMORRAGE

Of autopsy..... UNSATISFACTORY REQUESTED

PHYSICIAN.....
Underline the cause to which death should be charged statistically.

11. Industry or business.....

12. Name Elija Blaylock

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

14. Maiden name Guinna Summers

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

16. (a) Informant Mrs. Mary E. Blaylock

(b) Address Jackson MO

17. (a) Burial (b) Date thereof 4 10-1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Iona Cemetery

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?.....

18. (a) Signature of funeral director Wilson Stalls Seaburg

(b) Address Jackson MO

19. (a) April 10 (b) J. H. Kishner
(Date received local registrar) (Registrar's signature)

While at work?..... (Specify type of place)

(e) Means of injury.....

23. Signature Dr. Albert L. Lindall (M. D. or other)
Address Jackson, Mo Date signed 4/9/45

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

RECEIVED

District Health Officer No. 4th

District File Number 545-611

Date Filed 5-9-45

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 *Glen Wilson*

Licensed Embalmer No. 2828

P. O. Address *Jackson 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. man
Registrar's No. 130

Registration District No. 52 Primary Registration District No. 3009

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

1. PLACE OF DEATH:

(a) County Cape Girardeau
 (b) City or town Jackson
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
(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 Wm F. Blaylock
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____
 7. Birth date of deceased aug 17 1915
(Month) (Day) (Year)

8. AGE: Years 73 Months 7 Days _____ If less than one day _____ min.
 9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation _____
 11. Industry or business _____

12. Name _____
 13. Birthplace _____
(City, town, or county) (State or foreign country)
 14. Maiden name _____
 15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant _____
 (b) Address _____
 17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
 (b) Address _____
 19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
 (c) City or town _____
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month aug 1945 year 1945 hour _____ minute _____ M. _____
 21. I hereby certify that I attended the deceased from _____ 19____;
 that I last saw him _____ alive on _____ 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death _____
 Duration _____

Due to _____
 Due to _____
 Other conditions _____
(Include pregnancy within 3 months of death)
Chronic Nephritis

Major findings:
 Of operations _____
 Of autopsy _____
 ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) (a) Means of injury
 23. Signature Wm F. Blaylock (M.D. or other) do
 Address Jackson, Mo Date signed _____

SUPPLEMENTARY

13034