NOV 3 1930

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

31975

1. PLACE OF DEATH
County Worth Registration District No. 903
Township Lincoln Primary Registration District No. 6212
City Grant City (No. ..... St. ..... Ward)

File No. .....
Registered No. 73

2. FULL NAME Harrison Green Bleyloch

(a) Residence. No. ..... St. ..... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
M	White	Single

5a. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF —

Barker

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 20 1870

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60	6	9	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (CITY OR TOWN) Union Fork
(STATE OR COUNTRY) Gentry Co Mo

PARENTS

10. NAME OF FATHER James A Bleyloch
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Dont Know
(STATE OR COUNTRY) Dont Know
12. MAIDEN NAME OF MOTHER Elizabeth Adkins
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Dont Know
(STATE OR COUNTRY) Mo

14. INFORMANT Mrs Martha Dickey
(Address) Grant City Mo

15. FILED Oct 1 1930 John A Andrews
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 29 1930

17. I HEREBY CERTIFY, That I attended deceased from Sept 1 1930 to Sept 29 1930, that I last saw h... alive on Sept 28 1930 and that death occurred, on the date stated above, at 11:45 A.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Carcinoma of Stomach
41B
44A
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED .....
IF NOT AT PLACE OF DEATH? —
DID AN OPERATION PRECEDE DEATH? No DATE OF ..... No
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? None

(Signed) John Andrews, M. D
Oct 1 1930 (Address) Grant City

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Grant City Cem	Oct 1 1930
20. UNDERTAKER Andrews	ADDRESS Grant City

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.