

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

Do not use this space.

OCT 31 1930

File No. **30832**  
Registered No. **71**  
St. \_\_\_\_\_ Ward)

**1. PLACE OF DEATH**

County Missouri  
Township Jensen  
City \_\_\_\_\_ No. \_\_\_\_\_

Registration District No. 716  
Primary Registration District No. 5945

**2. FULL NAME**

(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.

*James Rufus Phelps*

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX <i>Male</i>		4. COLOR OR RACE <i>White</i>		5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <i>Married</i>	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>Ledygo Phelps</i>					
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <i>Aug 8 1853</i>					
7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.	
	<i>76</i>	<i>9</i>	<i>5</i>		

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Sept 12 1930*

17. I HEREBY CERTIFY, That I attended deceased from *Sept 2* 19*30* to *Sept 12 1930* that I last saw him alive on *Aug 17 1930* and that death occurred, on the date stated above, at *7:30 a.m.*

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
*Chronic Hypertension*  
*9:00*

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Rubber Tinner*

(b) General nature of industry, business, or establishment in which employed (or employer) *unknown*

(c) Name of employer \_\_\_\_\_

CONTRIBUTORY (SECONDARY) *unknown* (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Poplar Grove Mo*

10. NAME OF FATHER *Ledygo Phelps*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Kentucky*

12. MAIDEN NAME OF MOTHER *Mary Stacy*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Kentucky*

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS \_\_\_\_\_

(Signed) *W. J. Bell* M. D.  
*9/14 1930* (Address) *Cracker Mo.*

14. INFORMANT (Address) *George Walters Cracker Mo.*

15. FILED *9/14 30* *W. J. Bell* REGISTRAR

\*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 *Cracker Kentucky* DATE OF BURIAL *9/14 30*

20. UNDERTAKER *Paul Hoops* ADDRESS *Cracker Mo.*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S SIGNATURE STATE CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

