

No. 2
M-2-43
5-17-39
X35897

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 10 1945

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30847

State File No. _____

Registration District No. 164

Primary Registration District No. 3032

Registrar's No. 85

1. PLACE OF DEATH:
 (a) County Johnson
 (b) City or town Warrensburg
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Warrensburg Clinic & Hosp. Inc.
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 30 Min.
(Specify whether
 In this community 30 Min.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State None (b) County None 51
 (c) City or town None 7
(If outside city or town limits, write "RURAL") 2
 (d) Street No. None 0
(If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Michael Allen Phelps
 3. (b) If veteran, name war no 3. (c) Social Security No. NO

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Single
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Sep. 11 1945
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 0 0 0 hr. 30 min.

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

10. Usual occupation none

11. Industry or business _____

MOTHER FATHER { 12. Name Carl Wesley Phelps
 13. Birthplace Chilhowee, Mo.
(City, town, or county) (State or foreign country)
 14. Maiden name Winifred Leibst
 15. Birthplace Pratt Kansas
(City, town, or county) (State or foreign country)

16. (a) Informant Fannie Phelps,
 (b) Address Chilhowee, Mo.

17. (a) Burial (b) Date thereof 9-12-45
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Sunset Hill

18. (a) Signature of funeral director Sweeney-Phillips
 (b) Address Warrensburg, Mo.

19. (a) Sept 11 1945 (b) Leola M. Williams
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Sept day 11
 year 1945 hour 1 minute 29 PM.
 21. I hereby certify that I attended the deceased from Sept 11
 _____, 1945 to Sept 11, 1945
 that I last saw her alive on Sept 11, _____, 1945
 and that death occurred on the date and hour stated above.

Immediate cause of death primary atelectasis
atelectasis
 Due to not known
 Due to _____
 Other conditions Asystole
(Include pregnancy within 3 months of death)

PHYSICIAN
 Major findings:
 Of operations 16/6
 Of autopsy _____
 Underline the cause to which death should be charged statistically.

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?

(Specify type of place)
 While at work? _____ (e) Means of injury _____
 23. Signature Dr. Anna Smith
(M. D. or other)
 Address Warrensburg, Mo. Date signed 9-11-45

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

51
2
2

1001

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.....

Was Not Embalmed....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

J. Earl Priest

Licensed Embalmer No. **3 878**.....

P. O. Address **Warrensburg 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.