

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

Do not use this space.

35105

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City..... (No.) St. Ward)

File No.
Registered No. **9827**

2. FULL NAME

Amelia Phelps
(a) Residence. No. **2634 Randolph St.** Ward. (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)

Female Colored Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Sept. 2 1865*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day,hrs. ormin.
	<i>64</i>	<i>8</i>	<i>2</i>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Nil*
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *Batesville*
(STATE OR COUNTRY) *Arkansas*

10. NAME OF FATHER *James Morgan*

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

12. MAIDEN NAME OF MOTHER *Unknown*

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

14. INFORMANT *Julia Blackwell*
(Address) *2634 Randolph St.*

15. FILED *CCCT - 5 1927* *Max C. Starbuck*
19... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Oct. 4, 1929*

I HEREBY CERTIFY, That I attended deceased from *Aug 9 - 2, 1929* to *10 - 4 - 1929* that I last saw her alive on *10 - 10 - 1929* and that death occurred, on the date stated above, at *12:25 AM*.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

92A Acute Regurgitation
92A

(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) *Pralysis (cerebral hem)*
Apoplectic (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH *Unknown*

IF AN OPERATION PRECEDE DEATH, DATE OF

WAS THERE AN AUTOPSY *no*

WHAT TEST CONFIRMED DIAGNOSIS *Symptoms*
(Signed) *L. V. Hunt*, M. D.

, 19 (Address) *239 So. Jefferson*

*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

Washington Park Lane 10-8-29

20. UNDERTAKER

Peoples and Co. Franklin

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.

