

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

Do not use this space.

40796

**1. PLACE OF DEATH**

County Jackson Registration District No. 399  
 Township Waver Primary Registration District No. 100  
 City Keosauqua (No. 1326 Bates)

File No. 5173  
 Registered No. 5173  
 Sl. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence. No. 1326 Bates St. 12 Ward. \_\_\_\_\_  
 (Usual place of abode) (If nonresident give city or town and State)  
 Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Fe 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 16 1840

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
82 | 7 | 28

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work at home  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
 (c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) Va

10. NAME OF FATHER Daniel Aker

11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) Va

12. MAIDEN NAME OF MOTHER Mary Wink

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) Va

14. INFORMANT Eleanor Kelling (Address) Lee's Summit Mo

15. FILED 1716-28 M. M. Cronin REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 14 1928

I HEREBY CERTIFY, That I attended deceased from Dec 14, 1928, to Dec 14, 1928, and that I last saw him alive on Dec 14, 1928, and that death occurred, on the date stated above, at 8:40 a.m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Brain ch. pneumonia

CONTRIBUTORY (SECONDARY) senility (duration) 10 1/2 yrs. mos. ds.

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

19. DID AN OPERATION PRECEDE DEATH? No DATE OF \_\_\_\_\_

20. WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical  
 (Signed) Philip J. Baker, M. D.  
12/15, 1928 (Address) 1014 N. Olive

\*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 Boston Mo DATE OF BURIAL Dec 17, 1928

20. UNDERTAKER Mrs. Fauster ADDRESS City Mo

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

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.

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