

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

Do not use this space.

✓ 1548

1. PLACE OF DEATH

County Jackson Registration District No. 399 File No. 150
 Township Kaw Primary Registration District No. 1002 Registered No. 100
 City Keosauqua No. St Mary Hospital St. _____ Ward _____

2. FULL NAME

John Peter Welker
 (a) Residence, No. 311 Clinton place St. _____ Ward _____
 (Usual place of abode)
 Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE wh. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND or (or) WIFE of Bertha E Welker

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 18, 1858

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>70</u>	<u>10</u>	<u>21</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Grocery
 (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) Ind.

10. NAME OF FATHER Wm Welker

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Ind

12. MAIDEN NAME OF MOTHER _____

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) no record

14. INFORMANT (Address) Mrs Bertha Welker
311 Clinton place

15. FILED Jan 11, 1929 M. M. Croome REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 9 1929
 17. I HEREBY CERTIFY That I attended deceased from Dec 23, 1928, to Jan 9, 1929 that I last saw him alive on Jan 5, 1929 and that death occurred, on the date stated above, at 5 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Bronch - Pneumonia
1070 (above)

CONTRIBUTORY (SECONDARY) 1000
 (duration) 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? Cultural Chest Pelion
 (Signed) _____, M. D.
1-9, 1929 (Address) 1112 Fed Res Bldg.

*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 Forest Hill DATE OF BURIAL 1-11-29

20. UNDERTAKER Mrs C L Foster ADDRESS Keosauqua

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.

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

48
10
9
165
2
31
31

58 - 18

90 10-21