

COMMONWEALTH OF KENTUCKY  
State Board of Health  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

File No. 25276

PLACE OF DEATH  
County MuhlenbergVol. No. 11Registration District No. 125-1894Registered No. 27Inc. Town BerlinPrimary Registration District No. 6846

(If death occurred in a hospital or institution give its NAME instead of street and number.)

City \_\_\_\_\_

(No. \_\_\_\_\_)

St. \_\_\_\_\_

Ward \_\_\_\_\_)

3 FULL NAME James H. Kitzinger

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male white

4 COLOR OF RACE

5 Single

Married

Widowed

Divorced

(Write the word)

Widowed

6 DATE OF BIRTH

Sept 30 1884

(Month)

(Day)

(Year)

7 AGE

89

yrs.

mos.

da.

IF LESS than 1  
day ----- hrs.  
or ----- min?

8 OCCUPATION

(a) Trade, profession or particular kind of work

Miner

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

9 BIRTHPLACE

(State or country)

Kentucky

10 NAME OF MOTHER

11 BIRTHPLACE OF FATHER (State or country)

Kentucky

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or country)

Pa

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Bessie Myers(Address) Berlin Ky

15

Filed Nov 22 1924 W. H. Holloway

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

11 21 1924  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 1924, to \_\_\_\_\_, 1924.

that I last saw him alive on Oct 26 1924and that death occurred on the date stated above at 59 m.

The CAUSE OF DEATH\* was as follows:

Chronic Intestinal  
Nephritis(Duration) 26 yrs. mos. ds

Contributory (Secondary)

(Duration) \_\_\_\_ yrs. mos. d.

(Signed) C. D. Adams, M. D.  
1124, 1924 (Address) Center

\*State the Disease Causing Death, or, in deaths from Violent Causes state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

at place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ da. State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ da.  
Where was disease contracted,

if not at place of death? \_\_\_\_\_

Former or

usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Wheeler, S. G. Nov 21 1924

20 BURIAL PLACE

ADDRESS

J. L. Thomas Center