

Commonwealth of Kentucky  
STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

1 PLACE OF DEATH  
County *Madison*  
Vol. No. *12*  
Inc. Town *Berry Ky*  
City \_\_\_\_\_ (No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

File No. **11036**  
Registered No. *57*  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME *John C. Whitaker*

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *male* 4 COLOR OR RACE *white* 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) *married*

6 DATE OF BIRTH *May 10, 1851*  
(Month) (Day) (Year)

7 AGE *60 yrs. 11 mos. 13 ds.* If LESS than 1 day... hrs. or... min.?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work *mine labor*  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (state or country) *Ky*

10 NAME OF FATHER *Petchar Whitaker*

11 BIRTHPLACE OF FATHER (State or country) *14*

13 MAIDEN NAME OF MOTHER *Kelmar*

12 BIRTHPLACE OF MOTHER (State or country) *Ky*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) *Galy Whitaker*  
(Address) *Leicester 17*

15 *April 24 1912* Registrar *W. H. Hoover*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *April 23, 1912*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *April 16, 1912*, to *April 23, 1912*, that I last saw him alive on *April 23, 1912*, and that death occurred, on the date stated above, at *10:30* a.m.

The CAUSE OF DEATH\* was as follows:  
*Rheumatism and Erysipelas*  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory \_\_\_\_\_  
(Signed) *Leroy Welfis*, M. D.  
*4/24 1912* (Address) *Leicester Ky.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS of INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL

(1) LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)  
At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. in the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
Where was disease contracted, if not at place of death? \_\_\_\_\_  
Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL *Wickliffe Burial* DATE OF BURIAL *April 24, 1912*

20 UNDERTAKER *L. P. Thomas* ADDRESS *Leicester Ky.*

WRITE IN PENCIL WITH UNFADING INK—THIS IS A PERSISTENT RECORD

B. D.—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. See instructions on back of certificate.