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

Do not use this space.

1731

1. PLACE OF DEATH

County Lewis — Registration District No. 480 — File No.

Township Union — Primary Registration District No. 5645 — Registered No. 2

City ..... (No. ..... St. ..... Ward)

2. FULL NAME Kate Cora Kolthoff

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (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	White	Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 5th 1860

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
67	9	13	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House Wife

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Adams County
(STATE OR COUNTRY) Ill.

PARENTS

10. NAME OF FATHER John H.Kellerman

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

12. MAIDEN NAME OF MOTHER Susan Ricter

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

14. INFORMANT Adam Kellerman
(Address) Canton Mo.

15. FILED 1/20 1928 W S Ellery REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-18 1928

17. I HEREBY CERTIFY, That I attended deceased from Dec 27, 1927, to Jan 18, 1928 that I last saw her alive on Jan 18, 1928, and that death occurred, on the date stated above, at 8:10 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Heart failure

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....

(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? no DATE OF .....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) S. J. Lillard M.D.

, 19 (Address) Canton Mo

*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	DATE OF BURIAL
Midway	Jan 22 1928
20. UNDERTAKER	**ADDRESS**
A.A.Roberts	La Grange

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.

MAR 19 1928

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Lewis — Registration District No. 480 — File No.

Township Union — Primary Registration District No. 5645 — Registered No.

City (No. St. Ward)

2. FULL NAME Kate Cora Kolthoff

(a) Residence. No. St., Ward. (If nonresident give city or town and State)
(Usual place of abode)

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: F
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): W.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 5-1860

7. AGE — YEARS — MONTHS — DAYS — If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(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)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address)

15. FILED 5/6, 1928 W S Ellery REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 18 1928

17. I HEREBY CERTIFY, That I attended deceased from 19 to 19 that I last saw h alive on 19, and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Heart Failure
Aortic Stenosis
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 90a
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) S. J. Lillard M.D.
, 19 (Address) Canton Mo

*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 — DATE OF BURIAL 19

20. UNDERTAKER — ADDRESS

SUPPLEMENTARY

...RS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

...be properly classified. Exact statement of OCCUPATION is very important.

...be stated EXACTLY. PHYSICIANS should state

S-1731