

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

Do not use this space.  
*Devey*  
12943  
File No. \_\_\_\_\_  
Registered No. *298*  
St. \_\_\_\_\_ Ward \_\_\_\_\_

1. PLACE OF DEATH  
 County *Greene* Registration District No. *318*  
 Township \_\_\_\_\_ Primary Registration District No. *2001*  
 City *Springfield* (No. *1519 St. Louis*) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME *Mrs. Katalie Lohor*  
 (a) Residence. No. *1519 St. Louis St.* St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (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 *Wh.* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *married*

5A. IF MARRIED, WIDOWED OR DIVORCED HUSBAND OR (OR) WIFE OF *J.B. Lohor*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Oct 9 - 1873*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
*54 6 10*

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work *home*  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
 (c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) *Smith Co.*  
 (STATE OR COUNTRY) \_\_\_\_\_

10. NAME OF FATHER *H.S. Davis*

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

12. MAIDEN NAME OF MOTHER *Lura Wright*

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

PARENTS

14. INFORMANT *E. D. Davis*  
 (Address) *1014 City of Clg*

15. FILE NO. *4/19 28* REGISTRAR *O. G. Frost*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *4/19 1928*

17. I HEREBY CERTIFY, That *she* deceased on *4/18* 19*28* at *3 P.M.* that I last saw her *alive* on *4/18* 19*28*, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

18. THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
*terminal paralysis*  
*known* (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) *75* (duration) yrs. mos. ds.

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

19. DID AN OPERATION PRECEDE DEATH? *No* DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY? *No*  
 WHAT TEST CONFIRMED DIAGNOSIS?  
 (Signed) *James E. Dewey*, M. D.  
 (Address) *SPRINGFIELD, 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 *Greenlawn Cem.* DATE OF BURIAL *4/19 28*

20. UNDERTAKER *Olma Schmeiser* ADDRESS *534 St. Louis*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important.

