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

Do not use this space.

22362

1. PLACE OF DEATH
County Crawford
Township Kinderhill
City ~~Farmington~~ (No. ..... St. ..... Ward)

Registration District No. 230
Primary Registration District No. 5313

File No. .....
Registered No. .....

2. FULL NAME Catherine E Pancoast

(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.

AUG 26 1930

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) May 28 1846

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	84	1	28	

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

9. BIRTHPLACE (CITY OR TOWN) Danville
(STATE OR COUNTRY) Pennsylvania

PARENTS

10. NAME OF FATHER John Riffle
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Milton
(STATE OR COUNTRY) Pennsylvania
12. MAIDEN NAME OF MOTHER Sarah Gibson
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Milton
(STATE OR COUNTRY) Pennsylvania

14. INFORMANT Daisy Pancoast
(Address) Farmington Mo.

15. FILED Aug 1, 1930 G. G. A. Herzog REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 18 1930

17. I HEREBY CERTIFY, That I attended deceased from July 1 1930, to July 18 1930 that I last saw her alive on July 18 1930 and that death occurred, on the date stated above, at 12:15 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Interstitial Nephritis
131 (duration) 2 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? Clinical

(Signed) William S Brewer, M. D.
7/19/1930 (Address) St. Louis 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
Catholic Cemetery St. Louis Mo.	July 21st 1930
20. UNDERTAKER	ADDRESS
Jas. C. Hollow	Cuba Mo.

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.