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

Do not use this space.

30134 3942

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

1. PLACE OF DEATH
County Jackson Registration District No. .....
Township Kan Primary Registration District No. .....
City K. C. Mo. (No. 3204-E-6th St. ..... Ward)

2. FULL NAME Catherine De Priest
(a) Residence. No. 3204-E-6th St., 399 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. 1002 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)
Fe	White	Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct-9-1875

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	54	11	18	

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

PARENTS
10. NAME OF FATHER Billy Renfrow
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Mo.
12. MAIDEN NAME OF MOTHER Elizabeth McCormick
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Mo.

14. INFORMANT Mrs. C. D. Lysinger
(Address) 3206-E-6th St. K.C. Mo.

15. FILED 9/27, 1930 M. M. Crowe REGISTRAR asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept-27-1930

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1930, to Sept 27, 1930 that I last saw her alive on Sept 27, 1930 and that death occurred, on the date stated above, at 5:30 Am m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Arteriosclerosis
Myocarditis, Chronic
936
97 (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? Physical examination
(Signed) N. Rosenberg, M. D.
9/27, 1930 (Address) 843 Halleck Bldg

*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
Mt. Washington	Sept 30 1930
20. UNDERTAKER	ADDRESS
Mrs. C. L. Foster	K. C. 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.

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