

FILED OCT 18 1950

THE DEPARTMENT OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 35283
8272

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2019	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Anthony Hosp.		d. STREET ADDRESS (If rural, give location) 6009 Dewey 0	
3. NAME OF DECEASED (Type or Print) a. (First) Elizabeth		b. (Middle) Runge	
c. (Last) Runge		4. DATE OF DEATH (Month) (Day) (Year) 9/29/50	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH May 23, 1889
9. AGE (In years last birthday) 61		10. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Germany 4
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Herman Mueller	
13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Frank	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ---	
17. INFORMANT'S SIGNATURE OR NAME Frank J. Runge--6009 Dewey		ADDRESS	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Artery Disease</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR <u>H2O1</u>			
22. I hereby certify that I attended the deceased from <u>29 Sept, 1950</u> , to <u>29 Sept, 1950</u> , that I last saw the deceased alive on <u>29 Sept, 1950</u> , and that death occurred at <u>7:45 P. M.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>Charles A. Nester MD</u>		23b. ADDRESS <u>5708 S Compton</u>	
23c. DATE SIGNED <u>9-30-50</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>10/2/50</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>St. Peters Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis Co., Missouri</u>	
DATE REC'D BY LOCAL REG. <u>OCT 2 1950</u>		REGISTRAR'S SIGNATURE <u>J. B. Casater</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Wacker-Heldrich</u>		ADDRESS <u>3634 Gravois</u>	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADEING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed..... *Robert Wheeler*

Signed.....
Student Embalmer

Licensed Embalmer No..... *2178*

P. O. Address..... *St Louis Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.