

Health,
Wellfare
Public
Service

FILED NOV 16 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH.

318

1003

36122
STATE FILE NUMBER 8925

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

300
1-56

All symptoms were listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DePaul Hospital		Length of stay in lb	STREET ADDRESS 4920 Holly Hills		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last ALEXANDER RUNKAS			4. DATE OF DEATH Month Day Year Sep. 27 1956		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 13, 1887	9. AGE (In years last birthday) 69
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waiter-Retired 5 Yrs.	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Greece		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Peter Runkas			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO.	17. INFORMANT Address (Wife) Minnie G. Runkas 4920 Holly Hills		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral accident</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Coronary Thrombosis</u> DUE TO (c) <u>Prostatic Hypertrophy</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) <u>Lethargic Urinary Bladder 4201</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>2 wks</u>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE		
21. I attended the deceased from <u>Aug 10 1951</u> to <u>Sept 27, 1956</u> and last saw <u>her</u> alive on <u>Sept 26, 1956</u> Death occurred at <u>7:00 A.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Darryl Reich M.D.</u>		22b. ADDRESS <u>5633 S. Kingshighway</u>		22c. DATE SIGNED <u>9/27/56</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Sep. 29, 1956	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cem.		23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.	
24. FUNERAL DIRECTOR Kriegshauser 4228 S. Kingshighway			25. DATE RECD. BY LOCAL REG. SEP 28 1956	26. REGISTRAR'S SIGNATURE <u>J. Earl Smith M.D.</u>	

(Licensed Embalmer's Statement on Reverse Side)

HER

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, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed... *William B. White*

Licensed Embalmer No.

P. O. Address... *W.B. White*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.