

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-035440

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2720

STATE FILE NUMBER

AMENDED

FILED OCT 9 1961

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

|   |  |  |  |   |   |
|---|--|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>St. Louis</u>   |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Mo</u> b. COUNTY <u>St. Louis</u> |   |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Ladue</u>  |  | Length of stay in 1b <u>60 Years</u>   | c. CITY OR TOWN <u>Ladue</u>   |   | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u># 9 Pebble Creek Lane</u>  |  |  | d. STREET ADDRESS (If outside, give location) <u># 9 Pebble Creek Lane</u>   |   |   |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><u>Katherine Guthrie Runk</u>   |  |  | 4. DATE OF DEATH<br>Month Day Year<br><u>September 25, 1961</u>  |   |   |
| 5. SEX <u>Female</u>  | 6. COLOR OR RACE <u>White</u>          | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>10-26-1869</u>   | 9. AGE (last birthday) <u>91</u>  | IF UNDER 1 YEAR IF UNDER 24 HR<br>Months Days Hours Min.                          |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>  | 11. BIRTHPLACE (City and state or country) <u>CANADA</u>   |   | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>   |
| 13a. FATHER'S NAME <u>ROBERT JAMES GUTHRIE</u>  |  | 13b. MOTHER'S MAIDEN NAME <u>CATHERINE A. M. M. BROWNFIELD</u>   |  | 14. NAME OF HUSBAND OR WIFE <u>Charles Runk</u>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No None</u>   |  | 16. SOCIAL SECURITY NO. <u>None</u>  | 17. INFORMANT Address <u>Warson Road Mr Clifford F. Zell, Jr. 1111 So.</u>   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial failure with congestive heart failure</u>   |  |  |  |   | INTERVAL BETWEEN ONSET AND DEATH <u>2 yr</u>                                      |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.  |  |  |  |   |   |
| DUE TO (b) <u>Arteriosclerotic heart disease.</u>   |  |  |  |   |   |
| DUE TO (c) _____  |  |  |  |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)   |  |  |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |   |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 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>1959</u> to <u>Sept 25 '61</u> and last saw her <u>him</u> alive on <u>Sept 25 '61</u><br>Death occurred at <u>approx. 8 PM</u> <u>P</u> on the date stated above, and to the best of my knowledge, from the causes stated. |  |  |  |   |   |
| 22a. SIGNATURE <u>Miller Lamm M.D.</u> (Degree or title) <u>and Dr. Grace Bergner</u>   |  |  | 22b. ADDRESS <u>114 North Taylor Ave St Louis</u>  |   | 22c. DATE SIGNED <u>9-27-61</u>   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>   |  | 23b. DATE <u>9/27/61</u>   | 23c. NAME OF CEMETERY OR CREMATORY <u>Valhalla</u>   |   | 23d. LOCATION (City, town, or county) (State) <u>St. Louis Co, Mo</u>             |
| 24. FUNERAL DIRECTOR ADDRESS <u>Alexander &amp; Sons 6175 Delmar Bl</u>   |  | 25. DATE RECD. BY LOCAL REG. <u>9-27-61</u>  |  | 26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u>  |   |

**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 J. Allen Davis  
Licensed Embalmer No. 4083  
P. O. Address M.H.

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.