S. No. 2
-11-10-39
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

FILED MAR 12 1940

State File No. 4796

Registration District No. 7917 Primary Registration District No. 1003 Registrar's No. 1626

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2915a Indiana Av.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County
(c) City or town St. Louis 24
(If outside city or town limits write "RURAL")
(d) Street No. 2915a Indiana Av.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Gertrude Runde
3. (b) If veteran, name war —
3. (c) Social Security No. 489-01-0565
4. Sex Female
5. Color or race white
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Dec. (Month) 6 (Day) 1890 (Year)

8. AGE:	Years	Months	Days	If less than one day
	49	2	10	hr. min.

9. Birthplace St. Louis (City, town, or county) Mo. (State or foreign country) 0
10. Usual occupation Marker
11. Industry or business Hotel Jefferson
FATHER
12. Name Fred W. Runde 6
13. Birthplace (City, town, or county) Germany (State or foreign country)
MOTHER
14. Maiden name Augusta Schultz 1
15. Birthplace (City, town, or county) Germany (State or foreign country) 0
16. (a) Informant Katherine Runde
(b) Address 2915a Indiana Av.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-19-40 (Month) (Day) (Year)
(c) Place: burial or cremation Valhalla Cem
18. (a) Signature of funeral director Witt Bur. Lx Mo
(b) Address 2929 S. Jefferson Av
19. (a) (Date received by local registrar) FEB 17 1940 (b) J. F. [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 16 year 1940 hour 8 minute 10 a. M.
21. I hereby certify that I attended the deceased from Dec 6, 1939, to Feb. 16th, 1940; that I last saw her alive on Feb. 16th, 1940; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Chronic Myocarditis	1 yr
Due to Chronic Bronchiectasis (forbid)	6 yrs
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury
23. Signature Chas. F. Henke (M. D. or other) MD
Address 900 Russell Bld Date signed 2/16/40

(Licensed Embalmer's Statement on Reverse Side)

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 Edgar H Witt - Lic. Embalmer #2117 ~~Registered Apprentice No.~~ ~~working under my personal supervision.~~

Signed Paul A. Shankin

Licensed Embalmer No. 3472

P. O. Address 29298 Jefferson

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, above space should be left blank.