

FEB 4 1943

Registration District No. 93

Primary Registration District No. 5342

Registrar's No. 56

1. PLACE OF DEATH:

(a) County Wade  
(b) City or town Rural - Washington  
(c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution Life  
In this community Life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Wade  
(c) City or town So. Springfield Rural  
(d) Street No. ....  
(e) Citizen of foreign country? (Yes or No) 0  
If yes, name country.....

3. (a) PRINT FULL NAME Law Runyon

3. (b) If veteran, name war..... (c) Social Security No. ....

4. Sex Female 5. Color or race white  
6. (a) Single, widowed, married 2 divorced, widowed  
(b) Name of husband or wife Sim Runyon (c) Age of husband or wife if alive..... years  
7. Birth date of deceased March 16 1862  
(Month) (Day) (Year)

8. AGE: Years 80 Months 10 Days ..... If less than one day hr. .... min.

9. Birthplace unknown (City, town, or county) (State or foreign country) 9

10. Usual occupation Farmer - housewife

11. Industry or business.....

12. Name Yake Yokum  
13. Birthplace unknown (City, town, or county) (State or foreign country) 9  
14. Maiden name Susan Gillespie  
15. Birthplace unknown (City, town, or county) (State or foreign country) 9

16. (a) Informant Lois Clabough  
(b) Address So. Springfield, Mo.  
17. (a) Care Chapel (b) Date thereof 1 18 43  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Care Chapel

18. (a) Signature of funeral director Ralph Wilson  
(b) Address So. Springfield, Mo.  
19. (a) Jan 18 43 (b) Phyllis Lack  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 16  
year 43 hour 2 AM minute..... M.  
21. I hereby certify that I attended the deceased from 1-14  
1943 to 1-16 1943  
that I last saw him alive on 1-14 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Failure

Due to.....  
Due to.....  
Other conditions (Include pregnancy within 3 months of death) 938

Major findings:  
Of operations.....  
Of autopsy.....

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?  
While at work? (Specify type of place) (e) Means of injury.....  
23. Signature H. O. Cowan (M. D. or other) 0  
Address Springfield, Mo. Date signed 1-19-43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

RECEIVED

District Health Officer No. 6,

District File Number 243-146

Date Filed FEB 2 1943

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 Me  
....., Registered Apprentice No. ....  
working under my personal supervision.

Signed R. L. Hamischild

Licensed Embalmer No. 3737

P. O. Address Lockwood 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.