FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED JUL 21 1948

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 23967

Registration District No. 310

Primary Registration District No. 3058

Registrar's No. 130

1. PLACE OF DEATH:

(a) County St Charles

(b) City or town St Charles
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St Joseph's Hospital ()
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 48 hrs. (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lincoln 57

(c) City or town Troy 2
(If outside city or town limits, write "RURAL") 0

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Louis William Runkels

3. (b) If veteran, name war

3. (c) Social Security No. 489-28-47-25

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Beulah Agnes Runkles

6. (c) Age of husband or wife if alive years

7. Birth date of deceased May (Month) 6 (Day) 1892 (Year)

8. AGE: Years 56 Months 1 Days 24 If less than one day hr. min.

9. Birthplace Lincoln Co. (City, town, or county) Missouri () (State or foreign country)

10. Usual occupation Farmer

11. Industry or business Own Farm

FATHER
12. Name James Runkles
13. Birthplace Unknown (City, town, or county) Virginia (State or foreign country)

MOTHER
14. Maiden name Mary Koster
15. Birthplace Lincoln Co. (City, town, or county) Missouri () (State or foreign country)

16. (a) Informant Mrs. Beula A. Runkles
(b) Address Troy, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 5 '48 (Month) (Day) (Year)
(c) Place: burial or cremation Silex, Mo.

18. (a) Signature of funeral director Kemper Funeral Home
(b) Address Troy, Missouri.

19. (a) 7-7-48 (Date received local registrar) (b) Fannie Hamilton (Registrar's signature) 284

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 3
year 1948 hour minute M.

21. I hereby certify that I attended the deceased from 7/2 1948 to 7/3 1948
that I last saw him alive on 7/3 1948
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Perforated Peptic ulcer	1 day
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death) 1170	

Major findings:
Of operations no operation
Of autopsy Perforated peptic ulcer

PHYSICIAN
Underline the cause of 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 B. L. Newberry (M. D. or other) M.D.
Address St. Charles Mo. Date signed 7/3/48

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number
JUL 20 1948
Date Filed

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~~ XXX

, Registered Apprentice No.

working under my personal supervision.

Signed Joseph Marsh

Licensed Embalmer No. 3932

P. O. Address Troy, Missouri.

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

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Aug

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 130

1. PLACE OF DEATH:

(a) County St Charles

(b) City or town St Charles
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether

In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Louis W - Runkels

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased May 6 1899
(Month) (Day) (Year)

8. AGE: Years 56 Months 1 Days 24 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) July 7, 1948 (Date received local registrar) Fannie Hamilton (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month July 3 year 1948 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
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 (M. D. or other)

Address Date signed

SUPPLEMENTARY

5-23967