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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 20 1948

Registration District No. 318

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 31402

Registrar's No. 7870

1. PLACE OF DEATH:

(a) County St Louis

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

(c) Name of hospital or institution: DePaul Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 days (Specify whether years, months or days)

In this community 3 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St Charles

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

(d) Street No. Rural Rt 2
(If rural, give location)

(e) Citizen of foreign country? N.R. No (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Edward R Runge

3. (b) If veteran, name war World War 1

3. (c) Social Security No. 486-28-8522

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Theodosia Runge

6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased July 27 (Month) 1895 (Day) (Year)

8. AGE: Years 53 Months 1 Days 7 If less than one day ___ hr. ___ min.

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

10. Usual occupation Farmer

11. Industry or business Farm

FATHER
12. Name Albert Runge
13. Birthplace St Charles (City, town, or county) Mo (State or foreign country)

MOTHER
14. Maiden name Lula Stickel
15. Birthplace St Louis (City, town, or county) Mo (State or foreign country)

16. (a) Informant Mrs Theodosia Runge

(b) Address St Peters Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 6 1948 (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Cemetery

18. (a) Signature of funeral director Hackmann - Bane

(b) Address 326 North 6th St St Charles Mo

19. (a) SEP 7 1948 (Date received local registrar) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 4 year 1948 hour 12 minute 30 A M.

21. I hereby certify that I attended the deceased from June, 1938, to Sept 4, 1948; that I last saw him alive on Sept 4, 1948; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Carcinoma Thyroid	6 mo.
Due to Metastasis to Brain	1 mo.
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy Metastasis Brain.

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? Means of injury

23. Signature Nicholas J. Honich MD (M. D. or other)

Address 8702 Riverview Blvd. Date signed 9/7/48

N.J HONICH

(Licensed Embalmer's Statement on Reverse Side)

NOV 13 1948

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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

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