

FILED OCT 15 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **30547**  
**4129**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. \_\_\_\_\_

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

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Jackson</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <b>Nebr.</b> b. COUNTY <b>Douglas</b> |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Kansas City</b> |  | c. LENGTH OF STAY (In this place) <b>13 HOURS</b>  |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>General Hospital No. 1</b>                           |  | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Omaha</b>  |  |
|   |  | d. STREET ADDRESS (If rural, give location) <b>4715 No. 42</b>   |  |

|   |            |             |                       |  |
|---|------------|-------------|-----------------------|--|
| 3. NAME OF DECEASED (Type or Print) <b>Niles ROBERT</b> | a. (First) | b. (Middle) | c. (Last) <b>Runn</b> | 4. DATE OF DEATH (Month) <b>9</b> (Day) <b>26</b> (Year) <b>1949</b> |
|---|------------|-------------|-----------------------|--|

|                    |                               |   |                                     |   |   |   |
|--------------------|-------------------------------|---|-------------------------------------|---|---|---|
| 5. SEX <b>MALE</b> | 6. COLOR OR RACE <b>WHITE</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b> | 8. DATE OF BIRTH <b>JUNE 7-1885</b> | 9. AGE (In years last birthday) <b>64 YEARS</b> | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HRS. Hours _____ Min. _____ |
|--------------------|-------------------------------|---|-------------------------------------|---|---|---|

|  |   |   |  |
|--|---|---|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BRIDGEMAN</b> | 10b. KIND OF BUSINESS OR INDUSTRY <b>CHICAGO-NORTHWESTERN RR.</b> | 11. BIRTHPLACE (State or foreign country) <b>SWEDEN</b> | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b> |
|--|---|---|--|

|                                      |  |  |
|--------------------------------------|--|--|
| 13a. FATHER'S NAME <b>JOHAN RUNN</b> | 13b. MOTHER'S MAIDEN NAME <b>MATILDA UNKNOWN</b> | 14. NAME OF HUSBAND OR WIFE <b>MRS. ELLEN RUNN</b> |
|--------------------------------------|--|--|

|  |                               |  |
|--|-------------------------------|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b> | 16. SOCIAL SECURITY NO. _____ | 17. INFORMANT'S SIGNATURE OR NAME <b>MRS. ELLEN RUNN</b> ADDRESS <b>4715 NORTH 42ND ST. OMAHA NEBRASKA</b> |
|--|-------------------------------|--|

|   |   |  |                                  |
|---|---|--|----------------------------------|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION   |  | INTERVAL BETWEEN ONSET AND DEATH |
|   | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary occlusion</b>  |  |                                  |
|   | ANTECEDENT CAUSES<br>DUE TO (b) _____<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (c) _____ |  |                                  |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.   |   |  |                                  |

|                        |                                  |  |
|------------------------|----------------------------------|--|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|------------------------|----------------------------------|--|

|   |  |   |
|---|--|---|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify)        | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR?                      |

22. I hereby certify that I attended the deceased from Sept. 25, 1949, to Sept. 26, 1949, that I last saw the deceased alive on Sept. 25, 1949, and that death occurred at 2:30A m., from the causes and on the date stated above.

|   |   |                                 |
|---|---|---------------------------------|
| 23a. SIGNATURE <b>Wm. W. Hart</b> (Degree or title) | 23b. ADDRESS <b>Med. Dir. Gen'l Hosp.</b> | 23c. DATE SIGNED <b>9-26-49</b> |
|---|---|---------------------------------|

|  |                               |   |  |
|--|-------------------------------|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b> | 24b. DATE <b>SEPT 26 1949</b> | 24c. NAME OF CEMETERY OR CREMATORY <b>FORESTLAWN CEMETERY</b> | 24d. LOCATION (City, town, or county) (State) <b>OMAHA, NEBRASKA</b> |
|--|-------------------------------|---|--|

|   |  |   |
|---|--|---|
| DATE REC'D BY LOCAL REG. <b>9-26-49</b> | REGISTRAR'S SIGNATURE <b>Sheraldine Holmes</b> | 25. FUNERAL DIRECTOR'S SIGNATURE <b>D.H. Newcomer's Sons</b> ADDRESS <b>1331 SOUTH CREEK KANSAS CITY, MO.</b> |
|---|--|---|

*the [unclear]*

**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 .....  
Student Embalmer

Signed *Bernard L. Thomas*.....

Licensed Embalmer No. *4250*.....

P. O. Address *N.C. 110*.....

**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.