

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

393337

STATE FILE NUMBER

FILED DEC 9 - 1957

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1311

S. 300
ev. 1-57

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Joseph,</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mo. Meth. Hosp.</u>		Length of stay in lb <u>most of life</u>	d. STREET ADDRESS (If outside, give location) <u>1619 Faraon St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Percy</u> Middle <u>Runcie</u> Last <u>Runcie</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>24</u> Year <u>1957</u>			
---	--	--	--	--	--	--

5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>unknown 1874</u>	9. AGE (In years last birthday) <u>85</u>	FUNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
-----------------------	----------------------------------	---	---	--	---	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. employee</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad Co.</u>	11. BIRTHPLACE (City and state or country) <u>Lawrence, Kansas</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
---	--	---	--

13a. FATHER'S NAME <u>James S. Runcie</u>	13b. MOTHER'S MAIDEN NAME <u>Constance Fauntleroy</u>	14. NAME OF HUSBAND OR WIFE
--	--	-----------------------------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT <u>Elliott Marshall, Country Club Place, Mo.</u> Address <u>St. Joseph, Mo.</u>
--	--	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Generalized Arteriosclerosis</u>	<u>years</u>
	DUE TO (c) <u>diabetes mellitus 260X</u>	<u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>arteriosclerotic obliterans, lower extremities</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
---	--

20c. TIME OF INJURY Hour <u> </u> Month <u> </u> Day, Year <u> </u> a.m. <u> </u> p.m. <u> </u>
--

20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY <u> </u> STATE <u> </u>
---	--	--

21. I attended the deceased from <u>11/23/57</u> to <u>11/24/57</u> and last saw ^{her} / _{him} alive on <u>11/23/57</u> Death occurred at <u>4:30a.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Douglas J. Stallard, M.D.</u> (Degree or title)	22b. ADDRESS <u>902 Edmund</u>	22c. DATE SIGNED <u>11/26/57</u>
--	-----------------------------------	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>11/29/1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Mora Cemetery</u>	23d. LOCATION (City, town, or country) (State) <u>St. Joseph, Missouri</u>
--	--------------------------------	--	---

24. FUNERAL DIRECTOR <u>Heaton-Bowman</u>	ADDRESS <u>St. Joseph, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Dec. 2, 1957</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Robert Fulton</u>
--	-----------------------------------	---	--

(Licensed Embalmer's Statement on Reverse Side)

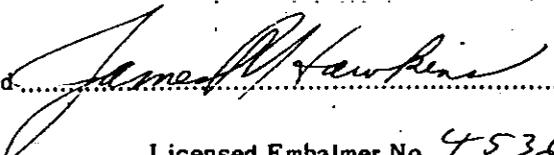
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 :
Signature of Student Embalmer

Signed 

Licensed Embalmer No. 4536

P. O. Address 314 So. 10th St.

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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