

FILLED NOV 24 1941

Registration District No. **791**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County.....
(b) City or town..... **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Jewish Hospital
(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 **Missouri** (b) County..... **000**
(c) City or town..... **St. Louis**
(If outside city or town limits, write "RURAL") **1712**
(d) Street No. **4562 Enright Ave.**
(If rural, give location) **9**
(e) Citizen of foreign country?..... **0** (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **Louis Machos**

3. (b) If veteran, name war..... **Unknown** 3. (c) Social Security No. **None**

4. Sex **Male / 1** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife..... **Eugenia** 6. (c) Age of husband or wife if alive..... **49** years

7. Birth date of deceased..... **ABOUT 1889**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
ABOUT 52 hr. min.

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

10. Usual occupation..... **Restaurant Owner**

11. Industry or business.....

12. Name..... **Nestora Machos**

13. Birthplace..... **Greece**
(City, town, or county) (State or foreign country)

14. Maiden name..... **Unknown**

15. Birthplace..... **Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant..... **Mrs. Eugenia Machos**

(b) Address..... **4562 Enright Ave.**

17. (a) **Burial** (b) Date thereof **10/28/41**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation..... **St. Matthews Cemetary**

18. (a) Signature of funeral director..... **Albert H. Hoppe**

(b) Address..... **4700 Washington Ave.**

19. (a) **OCT 27 1941** (b) **J. F. Bredak**
(Date received local registrar) (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **26th**
year **1941** hour **12** minute **40** M.

21. I hereby certify that I attended the deceased from **Oct 23.**
19 **41** to **time of death**, 19 **41**;
that I last saw him alive on **11³⁰ am**, 19 **41**;
and that death occurred on the date and hour stated above.

Immediate cause of death.....
Acute congestive failure - 7 days
Chr. Vent Disease:
Due to.....
1) Ecological - Rheumatic HD } yrs
2) Anatomical - Enlarg. Ht. }
Due to..... **CCVD Metab. Sten**
3) Physiological (Metab. Imbalance) }
4) Class IV - Aur. Fibrill. }
Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....
Of autopsy..... **None done**

Duration
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)..... **no**
(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 **Alfred Fleischman** (M. D. or other)
Address **634 W. Grand** Date signed **10-27-41**

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.....

Guy W Wilkinson

Licensed Embalmer No.....

3575

P. O. Address.....

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.