DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. 2162

FILED FEB 13 1943

Registration District No. 1

Primary Registration District No. 3020

Registrar's No. 65

1—5-42
5-17-39
I X32873

36
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2

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

**1. PLACE OF DEATH:**

(a) County: Franklin

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

(c) Name of hospital or institution: St. Francis Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community: 18 Years

**2. USUAL RESIDENCE OF DECEASED:**

(a) State: Missouri (b) County: Franklin 36

(c) City or town: Union R. R. 0
(If outside city or town limits, write "RURAL")

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

(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country: 0

3. (a) PRINT FULL NAME: William Machelett

3. (b) If veteran, name war: .....

3. (c) Social Security No.: .....

4. Sex: Male

5. Color or race: White

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

6. (b) Name of husband or wife: Henryeattie Machelett

6. (c) Age of husband or wife if alive: 60 years

7. Birth date of deceased: July 10, 1884
(Month) (Day) (Year)

8. AGE: Years 58 | Months 6 | Days 7 | If less than one day ..... hr. ..... min.

9. Birthplace: Germany (City, town, or county) 4 (State or foreign country)

10. Usual occupation: Carpenter

11. Industry or business: .....

FATHER
12. Name: August Machelett
13. Birthplace: Germany (City, town, or county) 4 (State or foreign country)

MOTHER
14. Maiden name: Ida Scharland
15. Birthplace: Germany (City, town, or county) 4 (State or foreign country)

16. (a) Informant: Henryeattie Machelett
(b) Address: Union, Mo.

17. (a) Buraal (Burial, cremation, or removal) (b) Date thereof: 1/20/43 (Month) (Day) (Year)
(c) Place: burial or cremation: UNION, MO.

18. (a) Signature of funeral director: Wurst Home
(b) Address: Union, Missouri

19. (a) Jan 19, 43 (Date received local registrar) (b) Lucile Ruether (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Jan. day 17 year 1943 hour 1 minute p.m. M.

21. I hereby certify that I attended the deceased from Jan 10, 1943, to to Jan 17, 1943, that I last saw ~~him~~ alive on Jan 17, 1943, and that death occurred on the date and hour stated above.

| Immediate cause of death | Duration |
|---|---|
| Tetanus | 1 wk. |
| 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): 036
(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: H. M. Lenny (M. D. or other) M.D.
Address: Union Mo. Date signed: 1-20-43

1161

(Licensed Embalmer's Statement on Reverse Side)

## 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 Wm H. Horn

Licensed Embalmer No. 3175

P. O. Address Union, Mo.

**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.**

S. No. 2B
M—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 2162

Registration District No. 116 Primary Registration District No. 3022 Registrar's No. 2

SUPPLEMENTARY

**1. PLACE OF DEATH:**
(a) County: Franklin
(b) City or town: Washington (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 years, months or days)
In this community

**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: Wm Machlett
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: July (Month) 10 (Day) 1885 (Year)
8. AGE: Years 58 Months 6 Days If less than one day hr. min.
9. Birthplace (City, town, or county) Germany (State or foreign country)
10. Usual occupation
11. Industry or business

MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
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) (Date received local registrar) (b) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Jan. day 17 year 1943 hour minute M.
21. I hereby certify that I attended the deceased from 19 ; that I last saw him alive on 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death: Tetanus

Due to: Accident 10-26-43 2 yr. hgts. Minor scalpes of face. Otobabiya punctured

Due to: Sebaceous cyst of scalp. Scar tissue removed

Other conditions (Include pregnancy within 3 months of death): 15 x Nov 2 Minor signs

Major findings: Of operations: extensively no x-ray

Of autopsy: 15 Feb 3

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)
(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: H M Denny (M. D. or other)
Address Date signed