

FILED AUG 8 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 25522

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 3069 Registrar's No. 1854

1. PLACE OF DEATH a. COUNTY <u>St Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>St Louis</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Richmond Mo</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Kirkwood Mo</u>	
c. LENGTH OF STAY (in this place) <u>10 days</u>		d. STREET ADDRESS (If rural, give location) <u>10341 Manchester Rd</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St Marys Hosp</u>			
3. NAME OF DECEASED a. (First) <u>MOTHER-MARY-THERESA</u>		b. (Middle) <u>BENEDINA</u>	
c. (Last) <u>MACHO</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>July 31 1950</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Sept 17-1894</u>
9. AGE (in years last birthday) <u>55</u>		10. MONTHS <u>10</u>	11. DAYS <u>14</u>
10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <u>Choir in Religion</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>St Agnes Hosp</u>	
11. BIRTHPLACE (State or foreign country) <u>Green Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>John Macho</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</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'S SIGNATURE OR NAME <u>Sister Mary Dorothy</u>	
ADDRESS <u>10341 Manchester Rd</u>		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Meenteric thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION <u>7/24/50</u>		19b. MAJOR FINDINGS OF OPERATION <u>gangrene of small bowel</u>	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		570.2	
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 <u>7/23/50</u> , 19 <u>50</u> , to <u>8/31/50</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>7/21/50</u> , 19 <u>50</u> , and that death occurred at _____ m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>James A. Marston M.D.</u>		23b. ADDRESS <u>607-n-Grand</u>	
23c. DATE SIGNED <u>8/2/50</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
24b. DATE <u>Aug 2-1950</u>		24c. NAME OF CEMETERY OR CREMATORY <u>St Peter Cem</u>	
24d. LOCATION (City, town, or county) (State) <u>Kirkwood Mo</u>		DATE REC'D BY LOCAL REG. <u>8-2-50</u>	
REGISTRAR'S SIGNATURE <u>Herbert R. Donke M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J.H. Beckey</u>	
ADDRESS <u>6536 Clayton Rd</u>		ADDRESS _____	

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

4005

Amarston

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

Robert M Murray

Licensed Embalmer No. *3749*

P. O. Address *St Louis 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.