

Health, Welfare Public Service

FILED NOV 5 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER  
37051

Registration District No. 309 Primary Registration District No. 6050 Registrar's No.

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>Saint Charles</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Charles</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Rural-Portage twsp.</b>		c. CITY OR TOWN <b>Rural-Portage twsp.</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Machens, Mo.</b>		d. STREET ADDRESS (If outside, give location) <b>Machens, Mo.</b>	
Length of stay in lb <b>34 yrs.</b>		Inside Limits (Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Reside on Farm (Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Henry</b> Last <b>Machens</b>			4. DATE OF DEATH Month <b>Oct.</b> Day <b>31</b> Year <b>1957</b>		
--	--	--	--	--	--

5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 11, 1922</b>	9. AGE (In years last birthday) <b>34</b>	IF UNDER 1 YEAR Months <b>8</b> Days <b>120</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
--------------------	-------------------------------	---	--	---	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>farming</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>OWN</b>	11. BIRTHPLACE (City and state or country) <b>Saint Charles, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
---	---	---	---

13a. FATHER'S NAME <b>William Machens</b>	13b. MOTHER'S MAIDEN NAME <b>Magdalena Kallenbach</b>	14. NAME OF HUSBAND OR WIFE <b>None</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. <b>495-22-0676</b>	17. INFORMANT <b>Aloysius Machens, Portage des Sioux</b>	Address
--	---	---	---------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute myo cardiac infarct</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b>
DUE TO (b) <b>arteriosclerotic heart disease</b>		
DUE TO (c)		<b>2 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a), (b), and (c). <b>4200</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

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 <b></b> Month, Day, Year <b></b> a.m. <b></b> p.m. <b></b>
---

20d. INJURY OCCURRED WHILE AT WORK <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	STATE
--	--	------------------------------	--------	-------

21. I attended the deceased from **Jan 1, 1957** to **Oct 31, 57** and last saw her/him alive on **October 30, 57**  
Death occurred at **October 31, 57 4:47** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>George F. Kister M.D.</b>	22b. ADDRESS <b>St. Charles Mo</b>	22c. DATE SIGNED <b>11-1-57</b>
--	---------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Nov. 2, 1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Francis Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Portage des Sioux, Mo.</b>
--	----------------------------------	---	--

24. FUNERAL DIRECTOR <b>W.C. Dallmeyer &amp; Sons, St. Charles, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>Nov. 7 1957</b>	26. REGISTRAR'S SIGNATURE <b>W. G. Mason</b>
--	--	---

(Licensed Embalmer's Statement on Reverse Side)

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.

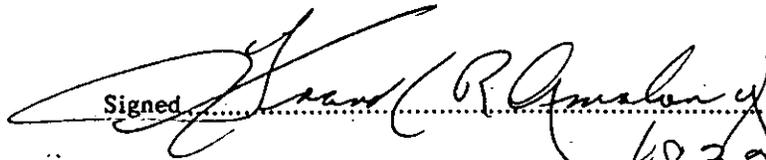
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

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. 1839

P. O. Address St. Charles

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.