

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-020716

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **5634**

FILED JUN 15 1962

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1	16
2	2169
3	
4	1
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12	75-0
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

SHOULD READ

ITEM NO.

1. PLACE OF DEATH a. COUNTY ST. LOUIS, MISSOURI		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION CITY HOSP. # 1		d. STREET ADDRESS 3216 Miami	
3. NAME OF DECEASED (Type or print) First MINNIE Middle Last MACHIK		4. DATE OF DEATH Month JUNE Day 5 Year 62	
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1/18/1866
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and state or country) Quincy, Ill.
13a. FATHER'S NAME William Reckmeyer		13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Nat Machik
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT August Haller, 1972a Lindenwood
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SIGMOID VOLVULUS DUE TO (b) REDUNDANT COLON DUE TO (c) 570.3 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) A.S.H.D. C. C.H.F.			INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <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 a.m. p.m. Month, Day, Year		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 5-18-62 to 6-5-62 and last saw her alive on 6-5-62	
21. I attended the deceased from 2:00 am on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE <i>J. E. Smith</i> (Degree or title)	
22b. ADDRESS 1515 LAFAYETTE AVE.		22c. DATE SIGNED 6-5-62 (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 6-7-62	23c. NAME OF CEMETERY OR CREMATORY Woodland Cemetery	23d. LOCATION (City, town, or county) Quincy, Ill.
24. FUNERAL DIRECTOR Albert H. Hoppe, Inc., 4700 Washington Blvd.		25. DATE RECD. BY LOCAL REG. JUN 5 1962	
26. REGISTRAR'S SIGNATURE <i>Karl Smith, M.D.</i>			

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 Guy W. Wilkinson

Licensed Embalmer No. 3575

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

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