

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

19607

**1. PLACE OF DEATH**

County .....

Registration District No. **791**

Township .....

Primary Registration District No. **1003**

City *S. V. Linn mo*

(No. *Jewish Hospital*)

File No. ....

Registered No. **5569**

St. .... Ward)

**2. FULL NAME**

*Max. Schen*

(a) Residence. No. *366 Bates* St. *1* Ward. ....

Length of residence in city or town where death occurred *27* yrs. mos. ds. How long in U.S., if of foreign birth? *31* yrs. mos. ds. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

**3. SEX**

*Male*

**4. COLOR OR RACE**

*white*

**5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)**

*Married*

**5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF**

*married*

**6. DATE OF BIRTH (MONTH, DAY AND YEAR)**

*Feb. 3 - 1872*

**7. AGE**

YEARS

MONTHS

DAYS

If LESS than 1 day, ..... hrs. or ..... min.

*59*

*3*

*9*

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work

*To Packer Saloon*

(b) General nature of industry, business, or establishment in which employed (or employer)

*Himself*

(c) Name of employer

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY)

*Austria (Galicja) (Hustga)*

**10. NAME OF FATHER**

*Jacob Schen*

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY)

*Austria Galicja*

**12. MAIDEN NAME OF MOTHER**

*Unknown*

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY)

*Russia*

**14. INFORMANT**

(Address)

*J. Schen 1237 ... as*

**15. FILED**

*17, 1963*

*M. C. ... REGISTRAR*

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)**

*May - 12 1931*

**17.**

I HEREBY CERTIFY, That I attended deceased from

*6*, 19*31*, to *5 - 12*, 19*31*.

that I last saw h. i. M. alive on *5 - 12*, 19*31*, and that death occurred, on the date stated above, at *7:05* p. m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

*Chronic myocarditis  
Cardiac decompensation*

(duration) ..... yrs. .... mos. .... ds.

**CONTRIBUTORY (SECONDARY)**

(duration) ..... yrs. .... mos. .... ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? *No* DATE OF

WAS THERE AN AUTOPSY? *No*

**WHAT TEST CONFIRMED DIAGNOSIS?**

*Clinical*

(Signed) *S. Gredewasser* M.D.

, 19 (Address) *Jewish Hospital*

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

**19. PLACE OF BURIAL, CREMATION, OR REMOVAL**

**DATE OF BURIAL**

*Cheva Kadoka Brnjak May 15 1931*  
**20. UNDERTAKER** *Oxenhander E. F.* ADDRESS *4822 East 4th*

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

