

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

Do not use this space.

31663

**1. PLACE OF DEATH**

County..... Registration District No. *212*  
Township..... Primary Registration District No. ....  
City *St. Louis* (No. *Pepper's Hospital*)..... St. .... Ward)

File No. ....  
Registered No. *8894*  
St. .... Ward)

**2. FULL NAME**

*Max Kantor*  
(a) Residence. No. *4630 McMillan St.*..... Ward. ....  
(Usual place of abode) (If nonresident give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX *Male* | 4. COLOR OR RACE *White* | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *single*

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *1*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Feb 26, 1911*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<i>17</i>	<i>6</i>	<i>7</i>	

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work *At home*  
(b) General nature of industry, business, or establishment in which employed (or employer).....  
(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN) *St. Louis*  
(STATE OR COUNTRY)

10. NAME OF FATHER *Samuel Kantor*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Russia*  
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER *Frieda Metor*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Russia*  
(STATE OR COUNTRY)

14. INFORMANT *Kantor*  
(Address) *4630 McMillan*

15. FILED *SEP - 1 1927*  
19. *Max C. Stanley*  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *9-3* 19 *28*

17. I HEREBY CERTIFY, That I attended deceased from *8-5-28*, 19... to *9-3-28*, 19... that I last saw him alive on *9-13-28*, 19... and that death occurred, on the date stated above, at *1100 A.*

18. THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
*Myocardial failure  
due to chronic valvular  
heart disease  
10 yrs. ?* (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) *90%* (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRIBUTED IF NOT AT PLACE OF DEATH? *?*

19. DID AN OPERATION PRECEDE DEATH? *No* DATE OF.....

20. WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) *Jesse A. Raach*, M. D.

*7/3* 1928 Address *Senior Jewish Hospital*

\*State the DISEASE CAUSING DEATH, or if 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 *Oni Amora* DATE OF BURIAL *9/4 1928*

20. UNDERTAKER *A. B. Burger* ADDRESS *4715 McPherson*

N. B.—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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

