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

Do not use this space.

17326

1. PLACE OF DEATH

County ..... Registration District No. 791 1003 File No. .....

Township ..... Primary Registration District No. ..... Registered No. 4349

City St Louis Mo (No. Home - 5840 Wabada St. ..... Ward)

2. FULL NAME Max Levitt

(a) Residence. No. 5840 Wabada St., 6 Ward. (If nonresident, give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? 35 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) ~~WIFE~~ OF Lena - Levitt

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown 1863

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
about	63	—	—	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Inspector City Water Works
(b) General nature of industry, business, or establishment in which employed (or employer) Unknown
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Russia

PARENTS
10. NAME OF FATHER Julian Levitt
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Russia
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Russia

14. INFORMANT Sam Levitt
(Address) 5840 Wabada

15. FILED May 2 1930 Max C. Starkloff REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 1st 1930

17. I HEREBY CERTIFY, That I attended deceased from May 1st, 1930, to May 1st, 1930 that I last saw him alive on May 1, 1930, and that death occurred, on the date stated above, at 8:00 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Apoplexy
(Cerebral Hemorrhage)
82A
102 (duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (SECONDARY) High Blood Pressure
(duration) 10 yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED? 74 M
IF NOT AT PLACE OF DEATH Same
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) J. R. Davis, M. D.
May 2, 1930 (Address) 1492 Hodiamont

*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
Beth-Hammedroth Hagodol	May 2 1930
20. UNDERTAKER	ADDRESS
Oxenhandler E. S.	4822 Easton Av

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.