

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

Do not use this space.

15333

1. PLACE OF DEATH

County Sullivan

Registration District No. 852

Township Milan

Primary Registration District No. 4518

City Milan (No.)

File No.

Registered No.

St. Ward

2. FULL NAME

Max Wilson Bertschman

(a) Residence, No. 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. ds. 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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb. 28, 1916

7. AGE YEARS 19 MONTHS 1 DAYS 9 If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. At Home
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. High School
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) Osborn, (STATE OR COUNTRY) Missouri

13. NAME Ray Simon Bertschman

14. BIRTHPLACE (CITY OR TOWN) Milan, (STATE OR COUNTRY) Missouri

15. MAIDEN NAME Golda Pearl Wilson

16. BIRTHPLACE (CITY OR TOWN) Sullivan County, (STATE OR COUNTRY) Missouri

17. INFORMANT Ray S. Bertschman (ADDRESS) Milan, Mo.

18. BURIAL, CREMATION, OR REMOVAL Oakwood Cem. Milan DATE April 8, 1935

19. UNDERTAKER C. A. Schoen (ADDRESS) Milan, Mo.

20. FILED May 9, 1935 Cleo Hagan Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 7, 1935

22. I HEREBY CERTIFY That I attended deceased from March 26, 1935 to April 7, 1935

I last saw him alive on March 8, 1935 Death is said to have occurred on the date stated above, at 8:30 a.m.

The principal cause of death and related causes of importance were as follows:

osteoma of antero-inferior
maxilla and cheek bone
of left side of face and this
started here many years
before death
due to sympathetic on death

Other contributory causes of importance:

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide Date of injury , 19

Where did injury occur (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

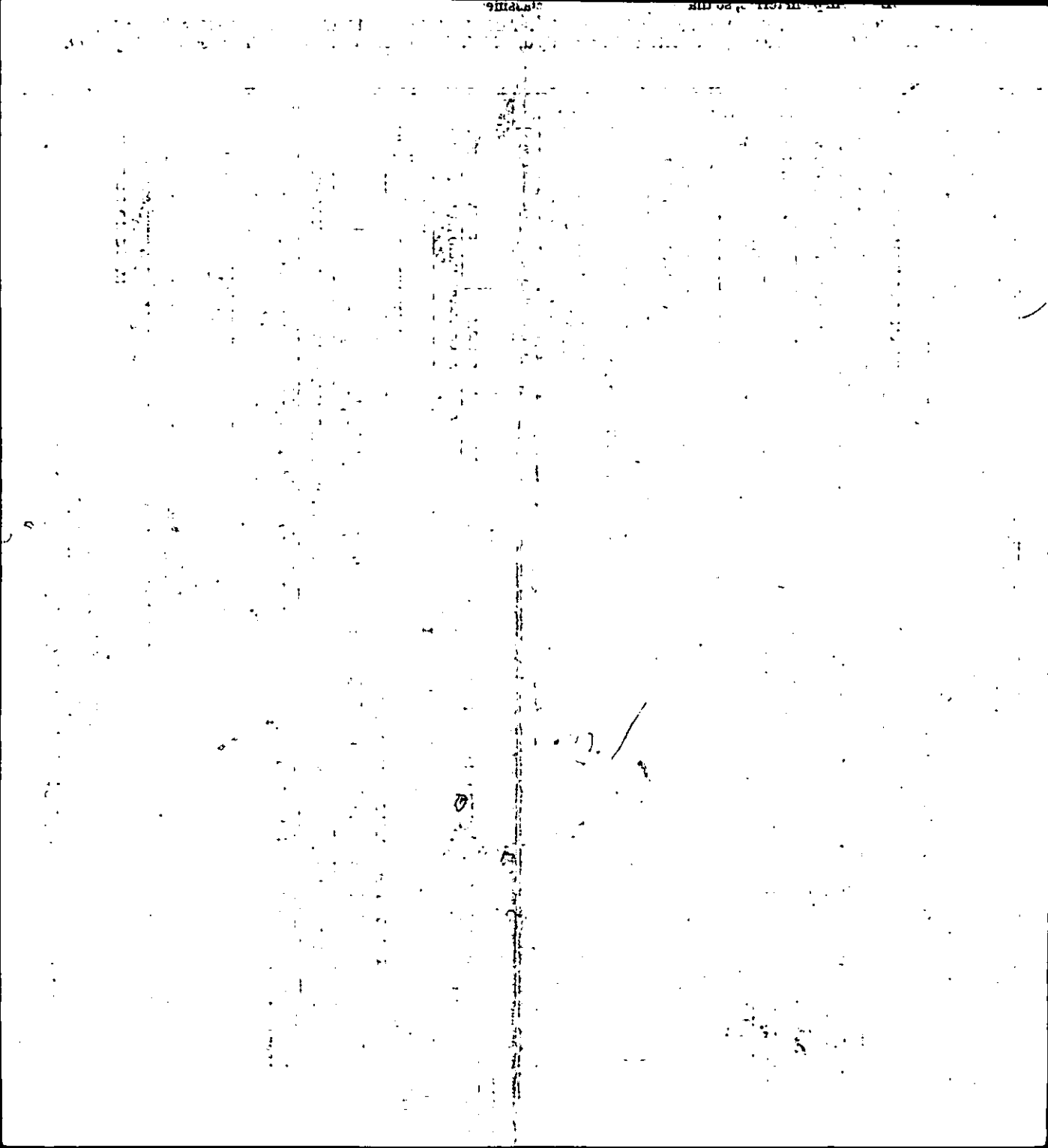
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Dr. J. S. Cochrane, D.O.

(Address) Milan, Mo.



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(No.

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Ward)

2. FULL NAME

Max Wilson Bertschman

(a) Residence, No.

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.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

M

4. COLOR OR RACE

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

S

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

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

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, hrs. or min.

19

1

9

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER FATHER

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE

DATE

19

19. UNDERTAKER (ADDRESS)

20. FILED

Oct 4 1935 Cleo Hagan
Registrar

21. DATE OF DEATH (MONTH, DAY, AND YEAR)

April 7 1935

22. I HEREBY CERTIFY, That I attended deceased from

I last saw him alive on

to have occurred on the date stated above, at

The principal cause of death and related causes of importance were as follows:

Edema of Antrum of nose and cheek bone of left side face, then started in lower maxillary bone then

Other contributory causes of importance:

to lymphatics & death

Malignancy - primary

Name of operation Spas Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external cause (violence), fill in also the following:

Accident, suicide, or homicide Date of injury

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) J. L. Carter, D.O., M. D.

(Address) J. L. Carter, Mo.

SEP 17 1935

S-15333