LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

36479

Registration District No. 791 File No.

Primary Registration District No. 1008 Registered No. 9873

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH

County

Township or Village or City St Louis Mo (No. City Hospital St.; 28 Ward) 8568

2 FULL NAME Odessy Hiel Haberis.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: Jan. 26, 1885 (Month) (Day) (Year)

7 AGE: 34 yrs. 8 mos. 17 ds. If LESS than 1 day, ...hrs. or ....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Munition worker
(b) General nature of industry business, or establishment in which employed (or employer):

9 BIRTHPLACE (City or town, State or foreign country): W. Va.

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Not Known

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Not Known

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant): Hospital Information
Otto R. Fritsch
(Address) City Hospital

15 Filed OCT 19 1918, 191 Marc C. Starkoff Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct 13, 1918 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Oct 10, 1918, to Oct 13, 1918, that I last saw him alive on Oct 13, 1918, and that death occurred, on the date stated above, at 8 45 a.m.

The CAUSE OF DEATH* was as follows:
Influenza
10
11A
10A (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia (Duration) ....yrs. ....mos. ....ds.

(Signed) Carl A. Heim M. D.
Oct 13, 1918 (Address) City Hospital

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death ....yrs. ....mos. 3 ds. In the State 2 yrs. ....mos. ....ds.
Where was disease contracted if not at place of death?
Former or usual residence Plymouth Hotel

19 PLACE OF BURIAL OR REMOVAL: Valhalla Cem DATE OF BURIAL: Oct 19, 1918

20 UNDERTAKER: Albert Hamel ADDRESS: 2320 Union

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

MARGIN RESERVED FOR BINDING

V. S. No. 2. A

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ... St.: ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

..... (Month) ....., 1..... (Day) (Year)

7 AGE

.....yrs.....mos.....ds.

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

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE
(City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

..... (Month) ....., 191..... (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191..... that I last saw h.....alive on ....., 191....., and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) .....yrs.....mos.....ds.

(Signed) .....M. D.

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death .....yrs.....mos.....ds. In the State .....yrs.....mos.....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191.....
20 UNDERTAKER	ADDRESS

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