

FILED MAR 3 1945
774
Registration District No. 774

Primary Registration District No. 4465

Registrar's No. 9

1. PLACE OF DEATH: Co. St. Francois
 (a) County Flat River Mo
 (b) City or town _____
 (c) Name of hospital or institution: 1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 (Specify whether _____)
 In this community _____
 years, months or days

3. (a) PRINT FULL NAME HENRY F Haber
 3. (c) Social Security No. _____
 8. (b) If veteran, name war _____

4. Sex Male 5. Color or race white
 6. (a) Single, widowed, married, divorced 1
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased: Mar 10 1897
 (Month) (Day) (Year)

8. AGE: Years 55 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace Mo. _____
 (City, town, or county) (State or foreign country)

10. Usual occupation W.P.A. work

11. Industry or business _____
 12. Name Franklin Haber
 13. Birthplace Mo.
 (City, town, or county) (State or foreign country)
 14. Maiden name Bertha Beaman
 15. Birthplace Mo.
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Henry Haber
 (b) Address Flat River Mo.

17. (a) _____ (b) Date thereof _____
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Wood Lawn

18. (a) Signature of funeral director Calderwood Bros.
 (b) Address Flat River Mo.

19. (a) 1-20-42 (b) Byrdie S. Bukhmetz
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 94
 (a) State Missouri (b) County 5
 (c) City or town Flat River, Mo 3
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) If foreign born, how long in U. S. A? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 25
 year 1942 hour 4 minute 45 P.M.
 21. I hereby certify that I attended the deceased from Oct 24
 _____, 1942, to Jan 25, 1942
 that I last saw him alive on Jan 25, 1942
 and that death occurred on the date and hour stated above.

Immediate cause of death Cancer stomach
 Due to Chronic ulceration of stomach
 Due to _____

Other conditions (Include frequency within 3 months of death) _____
 Major findings: Of operations H&E
 Of autopsy _____

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
 _____ (Specify type of place) _____
 While at work? _____ (e) Means of injury X

23. Signature J.W. Zuppan (M.D. or other) DO
 Address Flat River Date signed 1/29/42

Duration 34 months
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

94
5
2

RECEIVED
District Health Officer No. 17
Subject File Number 242-217
2-14-42
FILED

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....
Licensed Embalmer No.....
P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.