AUG 10 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 26159

Registration District No. 722 Primary Registration District No. 4463 Registrar's No. 966

1. PLACE OF DEATH:

(a) County St Francois

(b) City or town Elvins Mo (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: none (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution none (Specify whether

In this community years, months or days) Lpe. 103

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St Francois

(c) City or town Elvins Mo (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.? years.

3. (a) PRINT FULL NAME Donald Lee Subastin

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex Male

5. Color or race W

6. (a) Single, widowed, married, divorced —

6. (b) Name of husband or wife —

6. (c) Age of husband or wife if alive — years

7. Birth date of deceased July (Month) 2 (Day) 1940 (Year)

8. AGE: Years — Months 0 Days 21 If less than one day — hr. — min.

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

10. Usual occupation —

11. Industry or business —

FATHER
12. Name Lee Subastin
13. Birthplace Elvins Mo (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Vernia Medcalf
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Lee Subastin

(b) Address Elvins Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation Layne Cemetery

18. (a) Signature of funeral director Sparks F Ann

(b) Address Elvins Mo

19. (a) 7/22 40 (Date received local registrar) (b) C B Farrar (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 22--40 year hour minute 7 20 A.M.

21. I hereby certify that I attended the deceased from 7-2-40, 19, to 7-23-, 1940 that I last saw him alive on 7-22-40, 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Malnutrition	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN — Underline the cause to which death should be charged statistically

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

23. Signature (M. D. or other)

Address Date signed

(Licensed Embalmer's Statement on Reverse Side)

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS shou
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very im

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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 Murphy L. Sparks, Registered Apprentice No. 241, working under my personal supervision.

Signed Everett Sparks

Licensed Embalmer No. 2629

P. O. Address Elvins Mo.

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.

. No. 2B
—2-21-40
I X22659

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 26189

Registration District No. 772 Primary Registration District No. 4463 Registrar's No. 966

SUPPLEMENTARY

1. PLACE OF DEATH:
(a) County St Francois
(b) City or town Elvins
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(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.? years.

3. (a) PRINT FULL NAME Donald Lee Sebastian
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years
7. Birth date of deceased (Month) (Day) (Year)
8. AGE: Years | Months | Days 21 | If less than one day hr. min.
9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) 8/2/40 (Date received local registrar) (b) C B Stewart (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 22 year hour minute M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Duration

Immediate cause of death malnutrition –
Due to
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

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
23. Signature C B Stewart (M. D.)
Address Flat River Date signed 8/2/40