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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35825

LED NOV 6 1943

State File No. _____

Registration District No. 316

Primary Registration District No. 4462

Registrar's No. 31

1. PLACE OF DEATH:

(a) County St Francois Co.

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

(c) Name of hospital or institution: Residents
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community Life Time years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St Francois ⁹⁴

(c) City or town Elvins Mo. ⁷
(If outside city or town limits, write "RURAL")

(d) Street No. Gumbo St. ¹
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Moses Virgle Subastain

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 5. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife Ella Subastian 6. (c) Age of husband or wife if alive 53 years

7. Birth date of deceased Feb 22 1887
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>60</u>	<u>8</u>	<u>4</u>	_____ hr. _____ min.

9. Birthplace St Francois Co. N Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Miner

11. Industry or business St Joseph Lead Co.

12. Name Virgie Subastain

13. Birthplace St Francois Co.
(City, town, or county) (State or foreign country)

14. Maiden name Virgie Obannon

15. Birthplace St Francois Co.
(City, town, or county) (State or foreign country)

16. (a) Informant Memie Swinford

(b) Address Annopolis Mo.

17. (a) Burial (b) Date thereof Oct 28 43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Layne Cemetary

18. (a) Signature of funeral director Sparks Und Co.

(b) Address Flat River Mo.

19. (a) Oct-30-1943 (b) Byndie Burmester
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 26 19 43.
year _____ hour 6 minute A.M.

21. I hereby certify that I attended the deceased from Sept 1943 to Oct 26 19 43.
that I last saw him alive on Oct 23 19 43
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma gallbladder ^{Ups}

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death) 46 f

Major findings: Of operations _____

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? _____

While at work? _____ (Specify type of place) Means of injury _____

23. Signature N O Spahr (M. D. or other) _____

Address Elvins Mo Date signed 10-28-43

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 4
District File Number 1143-2868
Date Filed 11-5-43

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 Eugene Sparks

Licensed Embalmer No. 4287

P. O. Address 71st Street W

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, fact should be so stated above.

Registration District No. 3/6

Primary Registration District No. 6075

Registrar's No. 31

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 _____)
In this community _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Moses Vigne Substain
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 married

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased Feb 22
(Month) (Day) (Year)

8. AGE: Years 60 Months 8 Days _____ If less than one day _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

MOTHER: { 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) 10-30-43 (b) Byndie Bukhmeto
(Date received local registrar) (Registrar's signature)

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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day _____
year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____ on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

35625