. S. No. 2
DM—5-42
ev. 5-17-39
I X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 10 1944

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 30897

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 968

39
2
6

1. PLACE OF DEATH

(a) County GREENE

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

(c) Name of hospital or institution: 1030 CHERRY ST.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 18 MO. (Specify whether
In this community 72 YR.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Greene 39

(c) City or town Springfield,
(If outside city or town limits, write "RURAL")

(d) Street No. 2003 N. ROGERS.
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country ✓ 0

3. (a) PRINT FULL NAME WILLIAM ALFRED DYSART

3. (b) If veteran, name war NONE

3. (c) Social Security No. UNK.

4. Sex MALE 0

5. Color or race WHITE

6. (a) Single, widowed, married, divorced WIDOWER 2

6. (b) Name of husband or wife UNK.

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

7. Birth date of deceased MARCH (Month) 2 (Day) 1872 (Year)

8. AGE:	Years	Months	Days	If less than one day
✓	72	6	19	hr. min.

9. Birthplace GREENE CO. (City, town, or county) MO. (State or foreign country) 0

10. Usual occupation Retired R.R. Employee

11. Industry or business R.R. Construction Work

FATHER
12. Name W.C. Dysart
13. Birthplace Greene Co. (City, town, or county) Mo. (State or foreign country) 0

MOTHER
14. Maiden name Nancy Ketcherside
15. Birthplace Unk. (City, town, or county) Georgia (State or foreign country) 1

16. (a) Informant Mary Lou Goakey
(b) Address Springfield Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sep 23, 1944 (Month) (Day) (Year)
(c) Place: burial or cremation Green Lawn Cem.

18. (a) Signature of funeral director J.W. Klingner & Co.
(b) Address Springfield Mo.

19. (a) 9-22-44 (Date received local registrar) (b) Dr W. Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sep day 21 year 1944 hour 9 minute 30 A.M.

21. I hereby certify that I attended the deceased from 3-8, 1943 to 9/21/1944 that I last saw him alive on 9/20/1944 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Arteriosclerosis	2 yrs
Pyelitis	
Due to	
Due to Senility	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

133

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. E. Feller (M. D. ~~or other~~)

Address Springfield Mo. Date signed 9/21/44

984

(Licensed Embalmer's Statement on Reverse Side)

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 Ogle Stone Jr.

Licensed Embalmer No. 4176

P. O. Address Springfield

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.