

FILED MAR 20 1945
Registration District No. 58

Primary Registration District No. 3006

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

1. PLACE OF DEATH:

(a) County Boone

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

(c) Name of hospital or institution: Route 4
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 72 Years
(Specify whether years, months or days)

In this community 72 Years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Boone

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

(d) Street No. Route 4
(If rural, give location)

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

3. (a) PRINT FULL NAME SAMUEL SEARCY DYSART

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

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

7. Birth date of deceased 9 - 2 - 1872
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>72</u>	<u>5</u>	<u>9</u>	hr. _____ min. _____

9. Birthplace Boone County Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

12. Name Samuel Dysart

13. Birthplace Kentucky
(City, town, or county) (State or foreign country)

14. Maiden name Cynthia Searcy

15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. S.S. Dysart

(b) Address Route 4, Columbia, Mo.

17. (a) Burial (b) Date thereof 2-13-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Columbia Cemetery

18. (a) Signature of funeral director Parson Funeral Service
Columbia, Mo.

19. (a) 2-13-45 (b) Edna H Barber
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 11 year 1945 hour 11 minute 45 P.M.

21. I hereby certify that I attended the deceased from OUT to Feb. 11 - 1945

that I last saw him alive on Feb. 9 - 1945 and that death occurred on the date and hour stated above

Immediate cause of death Myocarditis Duration Send me

Due to _____

Due to _____

Other conditions Flu, A 3d
(Include pregnancy within 3 months of death)

Major findings: Of operations None

Of autopsy None

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) No

(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? No

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

23. Signature W.A. Dysart (M. D. or other) MD
Address Columbia, Mo. Date signed 2-12-45

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

1250

RECEIVED

District Health Officer No. 9,

District File Number _____

Date Filed 3-19-45

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 M. W. Whitaker

Licensed Embalmer No. 3893

P. O. Address Columbia, 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, fact should be so stated above.