

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

Registration District No. 140

Primary Registration District No. 3024

Registrar's No. 90

1. PLACE OF DEATH:  
 (a) County Howard  
 (b) City or town Richmond-Twp. Fayette, Mo.  
(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 35 yrs.  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County Howard  
 (c) City or town Rural  
(If outside city or town limits, write "RURAL")  
 (d) Street No. -----  
(If rural, give location)  
 (e) Citizen of foreign country? No. (Yes or No)  
 If yes, name country: -----

3. (a) PRINT FULL NAME Sam Frank Dysart  
 3. (b) If veteran, name war -----  
 3. (c) Social Security No. -----

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month Dec. day 22 year 1945 hour 1:45 minute P M.  
 21. I hereby certify that I attended the deceased from Dec 22 1945, to ----- 1945  
 that I last saw him alive on Dec 22 1945  
 and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife Eula Tisdal Dysart 6. (c) Age of husband or wife if alive 50 years  
 7. Birth date of deceased Sept. 4, 1892  
(Month) (Day) (Year)

Immediate cause of death: Coronary occlusion  
 Duration Stat.

8. AGE:	Years	Months	Days	If less than one day
	<u>53</u>	<u>3</u>	<u>18</u>	hr. <u>-----</u> min. <u>-----</u>

Due to -----  
 Due to -----  
 Other conditions (include pregnancy within 3 months of death) -----

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

Major findings: Of operations -----  
 Of autopsy -----  
 PHYSICIAN -----  
 Underline the cause to which death should be charged statistically.

MOTHER FATHER

11. Industry or business -----  
 12. Name Edward B. Dysart  
 13. Birthplace Boone County Missouri  
(City, town, or county) (State or foreign country)  
 14. Maiden name Hattie May Rowland  
 15. Birthplace Boone County Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Eula Dysart  
 (b) Address R. F. D. 5 Fayette, Mo.  
 17. (a) Burial (b) Date thereof 12/24/45  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Harrisburg Cemetery

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 -----

18. (a) Signature of funeral director Ralph A. Carr  
 (b) Address Fayette, Missouri  
 19. (a) 12-26-45 (b) Dorothy Jean Sahin  
(Date received local registrar) (Registrar's signature)

23. Signature Jaylle (M. D. or other) MD  
 Address ----- Date signed -----

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

RECEIVED

District Health Officer No. 8

District File Number.....

Date Filed 1-10-46

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 Ralph A. Carr

Licensed Embalmer No. 3340

P. O. Address Fregette 4mo

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.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. JanRegistration District No. 140Primary Registration District No. 3024Registrar's No. 90

## 1. PLACE OF DEATH:

(a) County Wayne  
 (b) City or town Wayne City  
 (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 \_\_\_\_\_  
 years, months or days)

3. (a) PRINT FULL NAME Sam J. Dupont

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 W

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Sept 4, 1892  
(Month) (Day) (Year)8. AGE: Years 53 Months 3 Days 30 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) Anne P. Durdell 23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature) Address \_\_\_\_\_ Date signed \_\_\_\_\_

## 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 \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive 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 \_\_\_\_\_

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

SUPPLEMENTARY

41343