

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 11 1946

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **5231**
Registrar's No. **198**

Registration District No. **128**

Primary Registration District No. **2000**

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: **Springfield Baptist Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 yr., 1 month**
In this community **(1)** years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Greene** **39**
(c) City or town **Springfield** **2**
(If outside city or town limits, write "RURAL")
(d) Street No. **906 S. Fremont** **6**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country:

3. (a) PRINT FULL NAME **MINNIE L. DYSART**
3. (b) If veteran, name war **UNK.** 3. (c) Social Security No. **None**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **February** day **26**, year **1946** hour **4:** minute **40 A.** M.
21. I hereby certify that I attended the deceased from **Jan** 19**45** to **Feb 26** 19**46**
that I last saw h^er alive on **Feb 25** 19**46** and that death occurred on the date and hour stated above.

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **John Dysart** 6. (c) Age of husband or wife if alive **Dec. 23, 1864**
7. Birth date of deceased **June 23, 1864**
(Month) (Day) (Year)

Immediate cause of death **Chronic Myocarditis** **397**
Due to **General Atherosclerosis**

8. AGE: Years **81** Months **8** Days **3** If less than one day hr. min.

Other conditions **Fracture of hip** **1945**
(Include pregnancy within 3 months of death)
(Red since then)

9. Birthplace **Unknown** **Missouri** (City, town, or county) (State or foreign country)
10. Usual occupation **Home**

Major findings: Of operations **930**
Of autopsy

MOTHER FATHER { 12. Name **UNK Saunders**
13. Birthplace **Unknown** **UNK 9** (City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **Unknown** **UNK 9** (City, town, or county) (State or foreign country)

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?

16. (a) Informant **James Saunders**
(b) Address **Route # 3, Springfield, Mo.**
17. (a) **Burial** (b) Date thereof **2/27/1946**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Maple Park Cemetery**

23. Signature **King D. Cressway** (M. D. or other) **MD**
Address **Springfield, Mo** Date signed **2/24/46**

18. (a) Signature of funeral director **Alma Lohmeyer Funeral Home**
(b) Address **Springfield, Missouri**
19. (a) **2-27-46** (b) **Dr WJ Haudley**
(Date received local registrar) (Registrar's signature)

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

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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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed..... *Lewis G. Scherpf*

Licensed Embalmer No. *38102*

P. O. Address..... *Springfield, 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.

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