

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED NOV 10 1949

State File No. **34262**

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

BIRTH NO. _____		REG. DIST. NO. <u>174</u>		PRIMARY REG. DIST. NO. <u>3035</u>		Registrar's No. <u>72</u>	
<b>I. PLACE OF DEATH</b> a. COUNTY <u>HA FAYETTE</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>HA FAYETTE</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>LEXINGTON</u>				c. LENGTH OF STAY (in this place) _____ c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>LEXINGTON</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>9th HIGHLAND</u>				d. STREET ADDRESS (If rural, give location) <u>9th HIGHLAND</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)		a. (First) <u>MARTIN</u>		b. (Middle) <u>KARL</u>		c. (Last) <u>DYRSSEN</u>	
4. DATE OF DEATH		(Month) <u>SEPT.</u>		(Day) <u>29</u>		(Year) <u>1949</u>	
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>SEPT. 16, 1898</u>	
9. AGE (In years last birthday) <u>51</u>		10. UNDER 1 YEAR <u>14</u>		11. UNDER 1 YEAR <u>0</u>		12. UNDER 1 HR. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GARAGE &amp; MOTOR CAR DEALER</u>				10b. KIND OF BUSINESS OR INDUSTRY _____			
11. BIRTHPLACE (State or foreign country) <u>WASHINGTON MO</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13a. FATHER'S NAME <u>JOHN DYRSSEN</u>		13b. MOTHER'S MAIDEN NAME <u>ANNIE M. WOLFE</u>		14. NAME OF HUSBAND OR WIFE <u>LAURA DYRSSEN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES WITH 2 YRS</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>LAURA DYRSSEN</u> ADDRESS <u>LEX. MO</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		<b>MEDICAL CERTIFICATION</b> I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cancer Parotid gland</u>				INTERVAL BETWEEN ONSET AND DEATH <u>over a year</u>	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.				DUE TO (b) _____ DUE TO (c) _____	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		DUE TO (c) _____				1421	
19a. DATE OF OPERATION <u>June 1948</u>		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma parotid gland</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____		21d. TIME OF INJURY (Month) _____ (Day) _____ (Year) _____ (Hour) _____ m.	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____				22. I hereby certify that I attended the deceased from <u>July</u> , 19 <u>49</u> , to <u>28 Sept</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>28 Sept</u> , 19 <u>49</u> , and that death occurred at <u>7 A m.</u> , from the causes and on the date stated above.	
23a. SIGNATURE <u>Ben W. Braden M.D.</u> (Degree or title)		23b. ADDRESS <u>Lexington Mo</u>		23c. DATE SIGNED <u>9/29/49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>Oct. 2 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>MEMORIAL PARK</u>		24d. LOCATION (City, town, or county) (State) <u>LEXINGTON, MO.</u>	
25. REC'D BY LOCAL REG. <u>9/29/49</u>		REGISTRAR'S SIGNATURE <u>Wm. C. ...</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>FORREST F. TEMPEL</u> ADDRESS <u>LEX. MO</u>			

RECEIVED

NOV 9

*Prash*

District Health Officer No. 3,

District File Number \_\_\_\_\_

Date Filed 11-9-49

NOV 10 1949

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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Student Embalmer

Signed *Geo. McTeague*

Licensed Embalmer No. 2983

P. O. Address Lewington, Pa.

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.