

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-016407

STATE FILE NUMBER

FILED MAY 12 1959

Registration District No. 323

Primary Registration District No. 4474

Registrar's No. 18

300  
1-57

4

1. PLACE OF DEATH a. COUNTY <b>Saline</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Saline</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Sweet Springs</b>		c. CITY OR TOWN <b>Miami</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Forsyth Restorium</b>		d. STREET ADDRESS (If outside, give location) <b>Rural route No.2</b>	
Length of stay in lb <b>3 months</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <b>Lillian Blanche Gibson Dysart</b>			4. DATE OF DEATH Month <b>May</b> Day <b>7th</b> Year <b>1959</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 22, 1892</b>	9. AGE (In years last birthday) <b>66</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	11. BIRTHPLACE (City and state or country) <b>Saline County, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Christopher C. Gibson</b>		13b. MOTHER'S MAIDEN NAME <b>Susan West</b>		14. NAME OF HUSBAND OR WIFE <b>Joseph W. Dysart</b>	

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. -----	17. INFORMANT <b>Mrs Josephine Morrison, Miami Mo. R. No. 2</b>	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pl. Lobar pneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>36 hrs.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Chronic myocarditis</b>	<b>Years.</b>
	DUE TO (c) <b>Chronic Oesophagitis</b>	<b>Years.</b>
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>023X</b>	

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour <b>11-30</b> Month, Day, Year <b>P.M.</b>	

20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b>Sweet Springs Mo</b>	COUNTY <b>Mo</b>	STATE <b>Mo</b>
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21. I attended the deceased from **Feb 59**, to **May 59** and last saw her alive on **5-7-59**  
Death occurred at **11-30 P.M.** on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Paul A. Roberts, M.D.</b>	(Date or title)	22b. ADDRESS <b>Sweet Springs Mo</b>	22c. DATE SIGNED <b>5-9-59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>5-10-1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Gardens</b>	23d. LOCATION (City, town, or county) (State) <b>Marshall, Missouri</b>
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24. FUNERAL DIRECTOR <b>Campbell-Lewis, Marshall, Mo.</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>May 9, 1959</b>	26. REGISTRAR'S SIGNATURE <b>Mary Monley</b>
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(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

MEDICAL CERTIFICATION  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Paul A. Roberts, M.D.

JUN 27 1958

VS  
MAR 29 1960

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 .....  
Signature of Student Embalmer

Signed James A. Lewis .....

Licensed Embalmer No. 4709  
P. O. Address Marshall .....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.