

FILED MAR 31 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **7621**

BIRTH NO. _____		REG. DIST. NO. <b>33</b>		PRIMARY REG. DIST. NO. <b>3006</b>		Registrar's No. <b>95</b>		
1. PLACE OF DEATH a. COUNTY <b>Boone</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Lafayette</b>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Columbia</b>		c. LENGTH OF STAY (in this place) <b>40 days</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Corder</b>		<b>6540</b>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Ellis Fischel State Cancer Hosp.</b>				d. STREET ADDRESS (If rural, give location) <b>R #1</b>				
3. NAME OF DECEASED (Type or Print) a. (First) <b>Charles</b> b. (Middle) <b>Pultz</b> c. (Last) <b>Dysart</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>1930 22 1950</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>3-25-1872</b>		
9. AGE (In years last birthday) <b>77</b>		IF UNDER 1 YEAR Months <b>11</b> Days <b>26</b>		IF UNDER 2 HRS. Hours <b>-</b> Min. <b>-</b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret'd. truck farmer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>farming</b>		11. BIRTHPLACE (State or foreign country) <b>Dover, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>W. H. Dysart</b>			13b. MOTHER'S MAIDEN NAME <b>Mary V. Dysart</b>			14. NAME OF HUSBAND OR WIFE <b>Jirdean Dysart</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Hospital Record</b>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary occlusion</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Carcinoma, Buccal mucosa</b>					INTERVAL BETWEEN ONSET AND DEATH <b>few minutes</b>  <b>Several years</b>  <b>14 1/2</b>  <b>2 years</b>	
19a. DATE OF OPERATION <b>4-8-48</b>		19b. MAJOR FINDINGS OF OPERATION <b>Recurrence 12/49 with Cervical nodes metastases</b>					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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)		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 <b>Feb. 10, 1950</b> , to <b>Mar. 22, 1950</b> , that I last saw the deceased alive on <b>Mar. 22, 1950</b> , and that death occurred at <b>2:30 p. m.</b> , from the causes and on the date stated above.								
23a. SIGNATURE <b>L. Allan Gay, M.D.</b>				(Degree or title)		23b. ADDRESS <b>State Cancer Hosp. - Columbia, Mo.</b>		
23c. DATE SIGNED <b>3-22-50</b>								
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <b>Mar 23 1950</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Resnap Concordia</b>		24d. LOCATION (City, town, or county) (State) <b>Concordia Mo</b>		
DATE REC'D BY LOCAL REG. <b>Mar. 23 1950</b>		REGISTRAR'S SIGNATURE <b>Mrs R.E. Palmer</b>		31		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>A. D. Willett Columbia Mo</b>		

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED MAR 28 1950  
District Health Officer No. 9,  
District File Number

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 *Lynnan H. Sprinkle*

Licensed Embalmer No. *4013*

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.