

FILED JAN 18 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **1730**
Registrar's No. **48**

BIRTH NO. _____ REG. DIST. NO. **198** PRIMARY REG. DIST. NO. **4311**

1. PLACE OF DEATH a. COUNTY Macon		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY Macon	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Callas	c. LENGTH OF STAY (In this place) -	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Callas Mo	
d. FULL NAME OF HOSPITAL OR INSTITUTION -		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print)	a. (First) Robert Lee	b. (Middle) Hisle	c. (Last) Hisle	4. DATE OF DEATH (Month) (Day) (Year) 1 - 2 - 50
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5. SEX Male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH 9-28-70	9. AGE (In years last birthday) 79	IF UNDER 1 YEAR Months Days	IF UNDER 1 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Clair Hisle	13b. MOTHER'S MAIDEN NAME Mary Mason	14. NAME OF HUSBAND OR WIFE -
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. -	17. INFORMANT'S SIGNATURE OR NAME Leonard Hisle	ADDRESS Callas Mo
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Apoplexy (Cerebral)		7 days
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis		
DUE TO (c) -			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senile dementia		334X 1 yr.	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from **Dec. 4, 1949**, to **Jan. 2, 1950**, that I last saw the deceased alive on **Jan 1, 1950**, and that death occurred at _____ m., from the causes and on the date stated above.

22a. SIGNATURE (Degree or title) Dr. G. W. Widlich, D.O.	22b. ADDRESS 2. Beaver, Mo.	22c. DATE SIGNED 1/2/50
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24a. BURIAL, CREMATION (REMOVAL) (Specify) Burial	24b. DATE 1-4-50	24c. NAME OF CEMETERY OR CREMATORY Concord Cem.	24d. LOCATION (City, town, or county) (State) Callas (Rural) Mo
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DATE REC'D BY LOCAL REG. 1-5-50	REGISTRAR'S SIGNATURE Josephine King	25. FUNERAL DIRECTOR'S SIGNATURE W. E. Edwards	ADDRESS Beaver, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED 1/10/50
MACON COUNTY HEALTH DEPARTMENT
County File No. 1/50/13.....
Date Filed 1/17/50.....

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 *J. G. Edwards*

Licensed Embalmer No. 1961

P. O. Address *Beris, 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.