

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JUN 24 1953

State File No. **20834**

BIRTH NO. _____ REG. DIST. NO. **43** PRIMARY REG. DIST. NO. **3007** Registrar's No. **250**

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| 1. PLACE OF DEATH a. COUNTY Butler | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Stoddard | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Poplar Bluff, | c. LENGTH OF STAY (in this place) 2 days | c. CITY (If outside corporate limits, write RURAL and give township) 1030 OR TOWN Bernie, R. 1. | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Doctors Hospital | | d. STREET ADDRESS (If rural, give location) Vine St. | |

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|-------------------------------------|--------------------------|-----------------------------|-------------------------|--|
| 3. NAME OF DECEASED (Type or Print) | a. (First) Lester | b. (Middle) Franklin | c. (Last) Hisaw, | 4. DATE OF DEATH (Month) (Day) (Year) June, 16, 1953 |
|-------------------------------------|--------------------------|-----------------------------|-------------------------|--|

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|--------------------|-------------------------------|---|--|---|------------------------|----------------------|-------|------|
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH June, 9, 1911. | 9. AGE (In years last birthday) 42 | IF UNDER 1 YEAR Months | IF UNDER 1 HRS. Days | Hours | Min. |
|--------------------|-------------------------------|---|--|---|------------------------|----------------------|-------|------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | 10b. KIND OF BUSINESS OR INDUSTRY Elevator Operator | 11. BIRTHPLACE (City and State or Foreign Country) Bernie, Mo. R. 1. | 12. CITIZEN OF WHAT COUNTRY? U. S. A. |
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| 13a. FATHER'S NAME Robert Hisaw, | 13b. MOTHER'S MAIDEN NAME Joan H. Spiller, | 14. NAME OF HUSBAND OR WIFE Ethel Hisaw |
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|--|-------------------------|---|---------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT'S SIGNATURE OR NAME Ethel Hisaw, Bernie, Mo. | ADDRESS |
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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, asthma, 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) Pulmonary Embolism | | minutes |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Crush injury DUE TO (c) | | 3 days |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | |

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| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION 802X 10 | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |
|------------------------|---|--|

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|--|--|---|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Railroad | 21c. (CITY, TOWN, OR TOWNSHIP) 1030 (COUNTY) (STATE) Bernie, Stoddard Mo. |
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| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) June 14 53 10 AM | 21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? Crushed by truck & Box Car |
|---|---|--|

22. I hereby certify that I attended the deceased from **6-14, 1953**, to **6-16, 1953**, that I last saw the deceased alive on **6-15, 1953**, and that death occurred at **4:15 A.M.**, from the causes and on the date stated above.

| | | |
|---|---------------------------------------|---------------------------------|
| 23a. SIGNATURE J. J. Biggs, M.D. (Degree or title) | 23b. ADDRESS Poplar Bluff, Mo. | 23c. DATE SIGNED 6-18-53 |
|---|---------------------------------------|---------------------------------|

| | | | |
|---|-----------------------------|---|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24b. DATE 6.17, 1953 | 24c. NAME OF CEMETERY OR CREMATORY Bernie Cem. | 24d. LOCATION (City, town, or county) (State) Bernie Mo. |
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| DATE REC'D BY LOCAL REG. 6/20/53 | REGISTRAR'S SIGNATURE J. J. Biggs | 25. FUNERAL DIRECTOR'S SIGNATURE Watkins Funeral Service, Dexter, Mo. | ADDRESS |
|---|--|--|---------|

489-0 (Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

6/22/53

BUTLER CO. HEALTH CENTER

FILE No. _____

AUG 27 1953

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 Walter Marsh Wathen

Licensed Embalmer No. 4717

P. O. Address Sevier, 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.