

ATTENDING PHYSICIAN'S CERTIFICATE

NOTICE: This certificate is to be completed by physician actually attending and treating the claimant. It is not to be completed by any Company Examiner who is not acting as claimant's private physician.

1. Full name of patient.	Ben L. Hester
2. Where did you first attend him? At his home, or your office, or where?	At his home
3. On what date were you first consulted on account of injury or sickness described on the other side hereof?	March 6th, 1933
4. During what period and how many times did you visit him at his home on account of this injury or sickness?	From March 6 19 33 To Sept. 12 19 33 Confined to bed & up & about Number of visits to home
5. On what date did you last give him actual and necessary treatment and what was the total number of treatments on account of this injury or sickness?	Last treatment Sept. 12 19 33 Total number of treatments In attendance since March 6 1933
6. State the precise nature of this injury or sickness and give your diagnosis as finally made.	ch- Bronchitis, attacks of pleurisy ch Brights with hypertension Pulmonary Tuberculosis
7. State in detail the symptoms observed by you during your attendance.	Cough - loss of weight - diminished expansion - Tubular breathing over upper half of chest - Rales over entire chest - Blood Pressure $\frac{160}{90}$ Weakness.
8. State in detail the exact condition at the present time and give your prognosis.	Condition poor - improvement very slow - Weakness - Prognosis poor
9. If the disease is tuberculosis, state by what tests the diagnosis has been confirmed.	Tubular breathing shortness of breath rales cough
10. How long will he be necessarily confined to house, wholly on account of this injury or sickness?	Patient is confined to bed part of time From 19 To 19
11. If not confined to house, how does he spend his time or purpose to do so?	and up and about part of time
12. Is he wholly unable to engage in any work, occupation or business suitable to one of his experience, training or qualifications?	Yes
13. If totally disabled at the present time, will such disability be permanent?	In my opinion yes.
14. If total disability will not be permanent, approximate a date work of any kind may be resumed.	
15. Can his ailment be successfully treated while continuing at work, either for full or part time? If not, state why.	No
16. Are you his regular family physician? How long have you been such?	Yes - 8 - 10 yrs.

Date signed **Sept. 12** 19**32**
Graduate of **St. Louis University**
Year graduated **1918**

Signature of Physician **Dr. W. W. Wild**
Residence: No. and Street **Resident Physician for
General Asbestos & Rubber Division**
City **North Charleston** State **S. C.**

Metropolitan Life Insurance Company

DISABILITY CLAIM DIVISION

Permanent Disability Section

Form O347
Apr, 1930
PRINTED IN U.S.A.

STATEMENT OF CLAIM FOR TOTAL AND PERMANENT DISABILITY BENEFITS

TO BE COMPLETED BY EMPLOYEE

1. What is your full name?	Ben L. Hester
2. Where do you live?	Street 14 Jenkins City N. Charleston State S.C.
3. Please give your personal description as follows:	Age 54 Sex Male Married Yes Color White
4. Nature of present sickness or injury?	Chest Shoulders Weakness in knees
5. On what date were you first totally disabled by this sickness or injury so that you were wholly unable to work?	March 4th, 1933
6. Have you since that time engaged in any occupation or business? If so, state particulars.	No
7. On what date were you first treated by a physician?	March 6th, 1933
8. Name all physicians who treated you since beginning of this disability.	W. W. Wild
9. Have you been confined to house by this sickness or injury? If so, how long?	From March 4 , 19 to April 1 , 19 33
10. If not confined to house, why are you unable to work?	Chest, Shoulders, Weakness in Knees
11. Are you now wholly unable to engage in any work, occupation or business?	Yes
12. If your disability is due to accident, answer the following questions: (a) Were you at work when accident happened? (b) When and where did accident happen? (c) Describe accident; tell how it happened.	
13. Are you receiving benefits for this disability from any other Insurance Company, Society or Lodge, etc.? If so, give particulars.	No Company _____ Amt. per week _____ No. of weeks payable _____
14. Are you insured under any other policies issued by this Company? If so, give numbers.	No

Date **Sept. 12, 1933** Signature of Employee **Ben L. Hester**

TO BE COMPLETED BY EMPLOYER

Group No. 2045-G Serial 460 Date of Issue 4-5-25 Amount of Insurance \$1,000.00	
1. Name of employee.	Ben L. Hester
2. On what date was he employed?	1-5-25
3. Was he a full or part time employee at beginning of this disability?	Full Time
4. In what occupation?	Weaver
5. On what date was he last at work?	March 4, 1933
6. Was he laid off prior to beginning of this disability? If so, on what date?	No
7. What was his weekly pay at beginning of disability?	\$25.00
8. Was disability due to accident in course of employment?	No
9. Has it been reported to the State Board or Commission or any Insurance Company as a Workmen's Compensation Claim? If not, state reasons why.	-
10. Are there any circumstances which would cause you to question the validity of the claim? If so, please give particulars.	No

Date **September 12, 1933** Signed **GENERAL ASBESTOS & RUBBER DIVISION of Raybestos-Manhattan, Inc.**
By **W.K. Muckenfuss**

ATTENDING PHYSICIAN'S CERTIFICATE REQUIRED ON OTHER SIDE