

No. 2
8-43
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **30340**
Registrar's No. **76**

FILED OCT 11 1945

Registration District No. _____ Primary Registration District No. **5-2-86 4126**

1. PLACE OF DEATH:

(a) County **Clark**

(b) City or town **Wyconda, Mo.**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Clark 23**

(c) City or town **Wyconda**
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? **No.** (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME **Alma Ebeling**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **16** year **1945** hour **5** minute _____ P.M.

21. I hereby certify that I attended the deceased from **Jan 1940** to **June 16 1945**
that I last saw her alive on **June 16 - 1945**
and that death occurred on the date and hour stated above.

4. Sex **Female** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **Single**

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **April 22 1875**
(Month) (Day) (Year)

Immediate cause of death **apoplexy cerebral**

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

8. AGE: Years Months Days If less than one day

70 1 24 hr. _____ min.

9. Birthplace **Scotland County, Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housekeeper**

11. Industry or business _____

Major findings: Of operations _____

Of autopsy **75a**

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

MOTHER, FATHER {

12. Name **William Ebeling**

13. Birthplace **Germany 4**
(City, town, or county) (State or foreign country)

14. Maiden name **Louise Jordan**

15. Birthplace **Germany 4**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. E. A. Gerth**

(b) Address **Washington, D.C.**

17. (a) **Burial** (b) Date thereof **June 18 1945**
(Burial, cremation, etc.) (Month) (Day) (Year)

(c) Place: burial **Wyconda Cemetery**

18. (a) Signature of funeral director **Gerth & Hooker**

(b) Address **9-28 Myarons, Mo**

19. (a) **9-28 45** (b) **J. H. Magee**
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

(Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature **B. F. Hutchinson** (M.D. or other) **P.O.**
Address **Wyconda, Mo** Date **Sept. 24-45**

1416 (Licensed Embalmer's Statement on Reverse Side)

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

OCT 19 1945

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.....

....., Registered Apprentice No.
working under my personal supervision.

Signed Geo. V. Baskett

Licensed Embalmer No. 1817

P. O. Address Wyaconda, 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.