

FEDERAL BUREAU OF INVESTIGATION  
 FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-026827

FILED VS. AUG 8, 1960

149

Registration District No. Primary Registration District No. 1-002 Registrar's No.

3710

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Jackson</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in lb <b>39 yrs</b>		c. CITY OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Research Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>207 N. Indiana</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>PAUL</b> Middle <b>C.</b> Last <b>ELLENBERGER</b>				4. DATE OF DEATH Month <b>7</b> Day <b>16</b> Year <b>60</b>			
5. SEX <b>Ma</b>	6. COLOR OR RACE <b>Wh</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>8-12-88</b>	9. AGE (last birthday) <b>71</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. valet</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>XX</b>	11. BIRTHPLACE (City and state or country) <b>Biel, Switzerland</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>No Record</b>			13b. MOTHER'S MAIDEN NAME <b>No Record</b>		14. NAME OF HUSBAND OR WIFE <b>Matilda Ellenberger</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>495-03-9248</b>		17. INFORMANT Address <b>Mrs. Katherine Rysen, Moline, Ill.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute myocardial infarction</b> DUE TO (b) <b>arteriosclerotic heart disease</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b> <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Chronic asthma &amp; Pulm. emphysema</b>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N. <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)				
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year						
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from <b>1-20-60</b> , to <b>7-16-60</b> and last saw <sup>her</sup> him <sup>live</sup> on <b>7-15-60</b> Death occurred at <b>5:00 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Wilson H. Miller, M.D.</b>				22b. ADDRESS <b>4620 Indep. Ave Kansas City, Mo.</b>		22c. DATE SIGNED <b>7-16-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>7-19-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Forest Hill Cemetery</b>		23d. LOCATION (City, town, or county) <b>Kansas City</b>		23e. (State) <b>Mo.</b>	
24. FUNERAL DIRECTOR <b>Wagner Funeral Home, K.C. Mo</b>			ADDRESS	25. DATE RECD. BY LOCAL REG. <b>7-18-60</b>	26. REGISTRAR'S SIGNATURE <b>Neve Marshall</b>		

DOCUMENT

MEDICAL CERTIFICATION

Wilson H. Miller

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*Alvin R. Hansen*

Licensed Embalmer No. 4158

P. O. Address 27, 6

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.