

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

=60-030223

FILED VS SEP 6 1960

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 914

STATE FILE NUMBER

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| 1. PLACE OF DEATH a. COUNTY <u>Greene</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u> | | c. CITY OR TOWN <u>Springfield</u> | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1623 Irving Foster Rest Home</u> | | d. STREET ADDRESS (If outside, give location) <u>1365 E. Blaine</u> | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>John</u> Last <u>Ebling</u> | | | 4. DATE OF DEATH Month <u>August</u> Day <u>31</u> Year <u>1960</u> | | |
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| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>11 Sept. 1876</u> | 9. AGE (last birthday) <u>83</u> | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | IF UNDER 24 HR Hours <u> </u> Min. <u> </u> |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OZARK Empire Fair Employee</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>Fair</u> | 11. BIRTHPLACE (City and state or country) <u>Illinois</u> | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> |
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| 13a. FATHER'S NAME <u>Charles Ebling</u> | 13b. MOTHER'S MAIDEN NAME <u>Mary See</u> | 14. NAME OF HUSBAND OR WIFE <u>None</u> |
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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) <u>No</u> | 16. SOCIAL SECURITY NO. <u>493-14-3151</u> | 17. INFORMANT Address <u>Tillie Ebling (Sister) Springfield, Mo.</u> |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) <u>Cerebral arteriosclerosis</u> | |
| | DUE TO (c) <u> </u> | |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Malnutrition</u> | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
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| 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.) |
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| 20c. TIME OF INJURY Hour <u> </u> Month, Day, Year <u> </u> | 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 <u>Springfield, Missouri</u> |
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| 21. I attended the deceased from <u>8-19-60</u> to <u>8/27/60</u> and last saw him alive on <u>8/27/60</u> Death occurred at <u>1:00</u> P.m. on the date stated above, and to the best of my knowledge, from the causes stated. |
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| 22a. SIGNATURE (Degree or title) <u>Carle H. Schroy MD</u> | 22b. ADDRESS <u>Springfield, Missouri</u> | 22c. DATE SIGNED <u>9/2/60</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>9/3/60</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u> | 23d. LOCATION (City, town, or county) (Specify) <u>Springfield, Missouri</u> |
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| 24. FUNERAL DIRECTOR ADDRESS <u>KLINGNER MORTUARY, INC. SPRINGFIELD MO.</u> | 25. DATE RECD. BY LOCAL REG. <u>9-2-60</u> | 26. REGISTRAR'S SIGNATURE <u>Effie S. Meeton</u> |
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DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

jhc

SEP 6 1960

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 J. B. K. [Signature]

Licensed Embalmer No. 3358

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do 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.