

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-028751  
STATE FILE NUMBER

FILED SEP 15 1958 Registration District No. 118 Primary Registration District No. 4188 Registrar's No. 32

1. PLACE OF DEATH a. COUNTY <b>Gasconade</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Gasconade</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Owensville</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Owensville</b> <b>0370</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>his residence</b>		Length of stay in 1b <b>45 yrs.</b>	d. STREET ADDRESS (If outside, give location) <b>412 W. Monroe</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Albert</b> Last <b>Ebling</b>			4. DATE OF DEATH Month <b>Sept.</b> Day <b>4</b> Year <b>1958</b>		
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5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 12, 1885</b>	9. AGE (In years last birthday) <b>73</b>	IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b>	IF UNDER 24 HRS. Hours <b>1</b> Min. <b>0</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dentist</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Dentistry</b>	11. BIRTHPLACE (City and state or country) <b>Callensburg, Pa.</b>	12. CITIZENSHIP OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Charles F. Ebling</b>		13b. MOTHER'S MAIDEN NAME <b>Rosena Neth</b>		14. NAME OF HUSBAND OR WIFE <b>Lillian Tappmeyer Ebling</b>	
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT <b>Mrs. Lillian Ebling Owensville, Mo.</b>	Address
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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) <b>Left Hemiplegia</b>			INTERVAL BETWEEN ONSET AND DEATH <b>9 days</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Cerebral Thrombosis</b>			<b>9 days</b>
	DUE TO (c) <b>Arteriosclerosis</b>			<b>5 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Diabetes Mellitus</b>			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 <b>12:15 P.M.</b> Month, Day, Year <b>Aug. 30, 58</b>	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 <b>Owensville, Mo.</b>	COUNTY <b>Gasconade</b>	STATE <b>Mo.</b>
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21. I attended the deceased from <b>Aug. 30, 58</b> to <b>Sept. 4, 58</b> last saw him alive on <b>9-3-58</b> Death occurred at <b>12:15 P.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE <b>Paula Ebling, M.D.</b>	22b. ADDRESS <b>Owensville, Mo.</b>	22c. DATE SIGNED <b>9-6-58</b>

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>9-6-1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>City Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Owensville, Mo.</b>
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24. FUNERAL DIRECTOR <b>Milford H H Winter OWENSVILLE</b>		ADDRESS <b>Owensville, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>September 6, 1958</b>	26. REGISTRAR'S SIGNATURE <b>Mrs. Marjorie Tappmeyer</b>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

NOV 6 1958

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 me, Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed Michael H. H. Winter

Licensed Embalmer No. 3838

P. O. Address OWENSOVILLE

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.