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-39  
23159

Registration District No. 85 Primary Registration District No. 1001 Registrar's No. 554

1. PLACE OF DEATH:  
(a) County Buchanan  
(b) City or town St Joseph  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
3829 Terrace  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 23 yrs years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Buchanan  
(c) City or town St Joseph  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3829 Terrace (If rural, give location)  
(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME Benjamin F. Mohler  
3. (b) If veteran, name war none  
3. (c) Social Security No. none

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month May day 24  
year 1941 hour 5 minute 25 AM.  
21. I hereby certify that I attended the deceased from Dec. 1939 to May 24 1941  
that I last saw him alive on May 24 1941  
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race white  
6. (a) Single, widowed, married, divorced, widowed  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased: March 4 1865  
(Month) (Day) (Year)

Immediate cause of death Coronary embolism Duration 1 hour  
Due to Chronic myocarditis (Unknown)  
Due to \_\_\_\_\_

8. AGE: Years 76 Months 2 Days 20 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.  
9. Birthplace Carlisle Pennsylvania  
(City, town, or county) (State or foreign country)

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

10. Usual occupation grocer  
11. Industry or business \_\_\_\_\_  
12. Name unknown  
13. Birthplace unknown 9  
(City, town, or county) (State or foreign country)  
14. Maiden name unknown  
15. Birthplace unknown 9  
(City, town, or county) (State or foreign country)

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs Harold Fleahorn  
(b) Address 3829 Terrace - St Joseph Mo  
17. (a) burial (b) Date thereof May 28 1941  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Ashland Cem  
18. (a) Signature of funeral director Neaton Beget Bourne  
(b) Address St Joseph Mo  
19. (a) May 28 1941 (b) E. J. Gross  
(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?  
55 While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature E. J. Gross (M. D. or other) 200  
Address 5008 King Hill Date signed 5-26-41

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

**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 5-24  
....., Registered Apprentice No. ....  
working under my personal supervision.

Signed Wm E. Summers

Licensed Embalmer No. 3007

P. O. Address 319 8010 St Paul

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

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