

OCT 26 1943
Registration District No. **59**

Primary Registration District No. **4097**

1. PLACE OF DEATH:

(a) County **Cass**
(b) City or town **Harrisonville**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
609 W. Meacham
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community **75 years** (Specify whether
years, months or days)

3. (a) PRINT FULL NAME **Mary Feindy Kohler**

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

4. Sex **Fe** 5. Color **wh** 6. (a) Single, widowed, married, divorced **m.**

6. (b) Name of husband **John Luther Kohler** 6. (c) Age of husband or wife if alive **75** years

7. Birth date of deceased **July 24 - 1868**
(Month) (Day) (Year)

8. AGE: Years **75** Months **2** Days **22** If less than one day _____ hr. _____ min.

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

10. Usual occupation **housewife**

11. Industry or business **Samuel D. Benight**

12. Name **Virginia**

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

14. Maiden name **Dorothy**

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

16. (a) Informant **Katherine Kohler**

(b) Address **609 W. Meacham**

17. (a) **Funeral** (Burial, cremation, or other) (b) Date thereof **Oct 19 43**
(Month) (Day) (Year)
(c) Place: burial or cremation **Orient Cemetery**

18. (a) Signature of funeral director **Atkinson Bros**
(b) Address **Harrisonville Mo**

19. (a) **Oct 23 1943** (Date received local registrar) (b) **Margaret Tolle** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Cass**
(c) City or town **Harrisonville Mo**
(If outside city or town limits, write "RURAL")
(d) Street No. **609 W. Meacham**
(If rural, give location)
(e) If foreign born, how long in U. S. A. **0** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **16**
year **1943** hour **4** minute **30 A.M.**

21. I hereby certify that I attended the deceased from **Oct 14 43** 19____ to **Oct 16** 19____
that I last saw her alive on **Oct 16 -** 19____
and that death occurred on the date and hour stated above.

Immediate cause of death **Organic heart disease
chronic myocarditis**

Due to _____
Due to _____

Other conditions (includes pregnancy within 3 months of death) **93d**

Major findings: Of operations _____
Of autopsy _____

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? _____ (c) Means of injury _____

23. Signature **J. M. East** (M. D. or other)
Address **Harrisonville Mo** Date signed **Oct 23**

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed *Floyd Atkinson*

Licensed Embalmer No. *3920*

P. O. Address *Harrisonville*

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, above space should be left blank.