

FEDERAL BUREAU OF INVESTIGATION  
 U.S. DEPARTMENT OF JUSTICE  
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**FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-039266**

STATE FILE NUMBER

MAILED

FILED VS DEC 9 1959 59

Primary Registration District No. 4097

Registrar's No. 192

1. PLACE OF DEATH a. COUNTY <b>CASS</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>CASS</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>HARRISONVILLE</b>		Length of stay in 1b <b>16 YRS</b>		c. CITY OR TOWN <b>HARRISONVILLE</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>609 W MECHANIC</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>609 W MECHANIC</b>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>LUTHER</b> Last <b>KOHLER</b>				4. DATE OF DEATH Month <b>Dec</b> Day <b>3</b> Year <b>1959</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</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>9-10-1868</b>	9. AGE (last birthday) <b>91</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>			10b. KIND OF BUSINESS OR INDUSTRY ---	11. BIRTHPLACE (City and state or country) <b>HARRISONVILLE, MO.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>John Kohler</b>			13b. MOTHER'S MAIDEN NAME <b>MARGARET WATKINS</b>		14. NAME OF HUSBAND OR WIFE <b>Luka B. Benight</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>489-30-7406</b>	17. INFORMANT <b>HAROLD KOHLER HARRISONVILLE, MO.</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>BRONCHOPNEUMONIA</b>						INTERVAL BETWEEN ONSET AND DEATH <b>5 DAYS</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>CONGESTIVE HEART FAILURE</b>						<b>6 MOS</b>	
DUE TO (c) <b>ARTERIOSCLEROTIC HEART DISEASE</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)						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	
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>3-3-56</b> to <b>12-3-59</b> and last saw him alive on <b>12-2-59</b> Death occurred at <b>3 AM</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>R. M. Wood</b> (Degree or title) <b>MD</b>				22b. ADDRESS <b>HARRISONVILLE MO</b>		22c. DATE SIGNED <b>12-4-59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>12-5-1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ORIENT Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>HARRISONVILLE, MISSOURI</b>			
24. FUNERAL DIRECTOR <b>ATKINSON Dickey</b> ADDRESS <b>HARRISONVILLE, MO.</b>			25. DATE RECD. BY LOCAL REG. <b>12-5-59</b>		26. REGISTRAR'S SIGNATURE <b>Mrs. Ray Sebree</b>		

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DEC 14 1959

STATEMENT BY LICENSED EMBALMER

JAN 20 1960

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 Robert W. Atkinson

Licensed Embalmer No. 4902

P. O. Address Hammond

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.