

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 19 1947
Registration District No. 207

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

5454

State File No. _____

Primary Registration District No. 575-8 Registrar's No. 11

1. PLACE OF DEATH:

(a) County Maries
 (b) City or town Dixon ~~Rural~~
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: _____
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether)
 * In this community 20 years
 years, months or days

-2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Maries 63
 (c) City or town Rural 0
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location) 0
 (e) Citizen of foreign country? _____ (Yes or No) 0
 If yes, name country _____

3. (a) PRINT FULL NAME William Allen Somers

3. (b) If veteran, name war _____ 3. (c) Social Security N499-24-2925

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Nellie Somers 6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased 6 2 1872
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
74 8 29 hr. _____ min.

9. Birthplace Indiana
 (City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER { 12. Name John Somers

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

14. Maiden name Mary Brown

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

16. (a) Informant Mrs. Inez Irwin

(b) Address Dixon, Missouri

17. (a) Burial (b) Date thereof 3/4/1947
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wheeler

18. (a) Signature of funeral director Fred H. Gilbert

(b) Address Dixon, Missouri

19. (a) 3-5-47 (b) Pauline Howard
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 1
 year 1947 hour 4 minute 10 P. M.

21. I hereby certify that I attended the deceased from 11-Feb-47
 1947 to March 1-1947
 that I last saw him alive on 28 March 1947
 and that death occurred on the date and hour stated above.

Immediate cause of death: Arteriosclerotic (coronary) heart disease
 Due to Arteriosclerosis
 Duration questionable

Due to _____
 Other conditions: hemiplegia from embolus 10-Feb-47
 (Include pregnancy within 3 months of death) date

Major findings:
 Of operations: _____
 Of autopsy: _____
 PHYSICIAN: _____
 -Underline the cause to which death should be charged statistically.

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?

While at work? _____ (Specify type of place)
 (e) Means of injury _____
 23. Signature E. Hughes (M.D. or other) 0
 Address Dixon, Mo Date signed 5-mch-47

APR 17 1948

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

Feb 3 - 1947

, Registered Apprentice No.

working under my personal supervision.

Signed

Fred H. Biller

Licensed Embalmer No. 2341

P. O. Address Dixon, Missouri

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

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

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. March

Registration District No. 207

Primary Registration District No. 5758

Registrar's No. 11

1. PLACE OF DEATH:

(a) County Marion
(b) City or town Rural Miller
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community 20 Years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Wm A. Somers

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

4. Sex M 5. Color or race W. 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased June 2
(Month) (Day) (Year)

8. AGE: 74 Years Months Days If less than one day hr. min.

9. Birthplace Indiana
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 3-5-47 (b) Pauline Sawyer
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration

Due to _____

Due to _____

Other conditions. _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

MOTHER LABEL

S-5454