

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

45374

FILED DEC 19 1957

STATE FILE NUMBER

Registration District No. 290 Primary Registration District No. 5985 Registrar's No. 162

1. PLACE OF DEATH a. COUNTY <u>Pulaski County Missouri</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>Macon</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fort Leonard Wood, Mo.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Decatur</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> <u>8128</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>USA Hospital</u>			Length of stay in lb <u>5 1/2 Hrs</u>		d. STREET ADDRESS <u>27 Montgomery Place</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>NORMAN</u> <i>First</i>				<u>GANDALL</u> <i>Middle</i>		<u>SOMMER</u> <i>Last</i>	
4. DATE OF DEATH		Month		Day		Year	
		<u>December</u>		<u>14,</u>		<u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>15 September 1935</u>		9. AGE (In years last birthday) <u>22</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Soldier</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>US Army</u>		11. BIRTHPLACE (City and state or country) <u>Decatur, Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>James McCoy Sommer</u>				14. MOTHER'S MAIDEN NAME <u>Helen Gandall Sommer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>348-28-7502</u>		17. INFORMANT <u>FORWIS TRUDE</u> <i>Address</i> <u>1000 E. 1st St. MO</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diffuse bilateral sub-dural hemorrhage</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 1/2 Hrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Laceration of right sigmoid dural sinus</u>							
DUE TO (c) <u>8354</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>33</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input checked="" 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.) <u>Automobile accident</u>				
20c. TIME OF INJURY Hour <u>2:00</u> Month <u>Dec</u> Day <u>14</u> Year <u>1957</u>							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <u>Minnesota St-Highway 17</u>		20f. CITY, TOWN, OR LOCATION <u>Ft Leonard Wood, Mo. Pulaski Missouri</u>			STATE <u>MISSOURI</u>
21. I HEREBY CERTIFY THAT THE DEATH OCCURRED ON <u>14 Dec 57</u> AT <u>7:30</u> A.M. ON THE DATE STATED ABOVE; AND TO THE BEST OF MY KNOWLEDGE, FROM THE CAUSES STATED.							
22a. SIGNATURE <u>James B. Whit, Capt, MC</u> (Degree or title)				22b. ADDRESS <u>US Army Hospital Fort Leonard Wood, Missouri</u>		22c. DATE SIGNED <u>14 Dec 57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>12-14-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>unknown</u>		23d. LOCATION (City, town, or county) (State) <u>Decatur Ill</u>		
24. FUNERAL DIRECTOR <u>HEDGES FUNERAL HOMES INC CROCKETT MO</u>			25. DATE RECD. BY LOCAL REG. <u>12-14-57</u>		26. REGISTRAR'S SIGNATURE <u>Charles Paul Anderson</u>		

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

Student
Signature of Student Embalmer

Signed *Clarence Gross*

Licensed Embalmer No. *4890*

P. O. Address *Waynesville*

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.