

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-040175

Registration District No. 749 Primary Registration District No. 1002 Registrar's No. 5555 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB  
 AMENDED

VS 300  
 Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

SHOULD READ

BY AFFIDAVIT OF

|   |   |   |  |
|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>JACKSON</u>   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u>                  |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>KANSAS CITY</u>   |   | Length of stay in 1b<br><u>42 YEARS</u>   | c. CITY OR TOWN <u>KANSAS CITY</u><br>Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>MANORAN MEDICAL CENTER</u>  |   | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   | d. STREET ADDRESS (If outside, give location)<br><u>803 WEST 48th STREET</u><br>Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>FRED</u> Middle <u>CLIFFORD</u> Last <u>SOMERS</u>  |   |   | 4. DATE OF DEATH<br>Month <u>OCTOBER</u> Day <u>11</u> Year <u>1963</u>  |
| 5. SEX<br><u>MALE</u>   | 6. COLOR OR RACE<br><u>WHITE</u>  | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br><u>1-22-1919</u>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>MANUFACTURER'S REPRESENTATIVE</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>F. C. SOMERS COMPANY</u>  | 11. BIRTHPLACE (City and state or country)<br><u>CLEVELAND, OHIO</u>   |
| 13a. FATHER'S NAME<br><u>FRED C. SOMERS</u>   |   | 13b. MOTHER'S MAIDEN NAME<br><u>EULA BROWN</u>  | 14. NAME OF HUSBAND OR WIFE<br><u>MRS. JAN ELLE SOMERS</u>   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   (If yes, give war or dates of service)<br><u>YES WORLD WAR II</u>   |   | 16. SOCIAL SECURITY NO.<br><u>-</u>   | 17. INFORMANT<br><u>Mrs. JAN ELLE SOMERS</u><br>Address <u>6545 SAGAMORE ROAD</u><br><u>MISSION HILLS KANS.</u>  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:  |   |   | INTERVAL BETWEEN ONSET AND DEATH   |
| IMMEDIATE CAUSE (a) <u>Fractured skull</u>  |   |   |  |
| DUE TO (b) <u>with brain damage</u>   |   |   |  |
| DUE TO (c)  |   |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I<br><u>Treated for pneumonia</u>   |   |   | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input 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.)<br><u>unknown how or when</u>                                  |  |
| 20c. TIME OF INJURY<br>Hour <u>          </u> Month, Day, Year<br>a.m. <u>          </u> p.m. <u>          </u>   | 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.)<br><u>          </u>   | 20f. CITY, TOWN, OR LOCATION<br><u>Kansas City</u>  | COUNTY<br><u>Jackson mo</u>   | STATE  |
| 21. I attended the deceased from <u>          </u> to <u>          </u> and last saw her alive on <u>          </u> .<br>Death occurred at <u>12:50 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated. |   |   |  |
| 22a. SIGNATURE (Degree or title)<br><u>Hugh H. Owens Coroner</u>  |   | 22b. ADDRESS<br><u>152 Union Station</u>  | 22c. DATE SIGNED<br><u>10/12/63</u>  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>  | 23b. DATE<br><u>OCT. 14, 1963</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Mt. Moriah Cemetery</u>  | 23d. LOCATION (City, town, or county) (State)<br><u>KANSAS CITY MISSOURI</u>   |
| 24. FUNERAL DIRECTOR<br><u>D.W. NEWCOMER'S SONS - KANSAS CITY, MISSOURI</u>   |   | DATE RECD. BY LOCAL REG.<br><u>10-14-63</u>   | 26. REGISTRAR'S SIGNATURE<br><u>Bessie Smith</u>   |

USE BLACK INK OR TYPEWRITER RIBBON

(Licensed Embalmer's Statement on Reverse Side)

Dr. Wm. H. ...  
152 ...  
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**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 EIDON NOKKIS Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student Eldon Harris  
Signature of Student Embalmer

Signed Dean W. Huff

Licensed Embalmer No. 4914

P. O. Address Indy, Mo.

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.