

STATE OF MONTANA
Bureau of Vital Statistics
Certificate of Death

DUPLICATE

1 PLACE OF DEATH

County *Blaine*

Township

City *Kalispell*

or Village

No. *Sister Hospital*

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

File No. *2068*

Registered No. *116*

2 FULL NAME *Anna Elizabeth Somes*

(a) Residence. No. *815-3 Ave. E.*

(Usual place of abode)

St.

Ward.

(If non-resident give City or Town and State)

Length of residence in city or town where death occurred

yrs

mos

days

How long in U. S., if of foreign birth?

yrs.

mos.

days

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *white* 5 Single, Married, Widowed or Divorced (Write the word) *widowed*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Joseph T. Somes*

6 DATE OF BIRTH (month, day, and year) *March 21-1849*

7 Age 69 Years 6 Months 8 Days IF LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *at home*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Troy*

(State or country) *N.Y.*

10 NAME OF FATHER *John Somes*

11 BIRTHPLACE OF FATHER (City or Town, State or Country) *England*

12 MAIDEN NAME OF MOTHER *Marj Partridge*

13 BIRTHPLACE OF MOTHER (City or Town, State or Country) *England*

14 Informant *M. P. Somes*

(Address) *Kalispell Mont*

15 Filed *Sept 30 1918*

W. H. Fuson
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Sept. 29 1918*

17 I HEREBY CERTIFY, that I attended deceased from *Sept 25 1918* to *Sept 29 1918*

that I last saw him alive on *Sept 29 1918*

and that death occurred, on the date stated above, at *9 P.M.*
The CAUSE OF DEATH* was as follows:

*Cerebral apoplexy
(Hemorrhage)*

(duration) yrs. mos. *4* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *no* Date of

Was there an autopsy? *no*

What test confirmed diagnosis? *no*

(Signed) *A. Brassett* M. D.

Sept 30 1918 (Address) *Kalispell*

* State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 Place of Burial, Cremation or Removal Date of Burial

Conrad Cem. Oct 1 1918

20 UNDERTAKER

ADDRESS

W. H. Sherman Kalispell