INDIANA STATE BOARD OF HEALTH
DIVISION OF VITAL RECORDS
MEDICAL CERTIFICATE OF DEATH

Local No. ________ State No. 62-030263

1. PLACE OF DEATH a. COUNTY: Clay
b. CITY, TOWN, OR LOCATION: Knightsville Ind
c. Length of Stay in 1b: Lifetime
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Knightsville Indiana
e. IS PLACE OF DEATH INSIDE CITY LIMITS? YES [x] NO [ ]

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Indiana b. COUNTY: Clay
c. CITY, TOWN, OR LOCATION: Knightsville
d. STREET ADDRESS:
e. IS RESIDENCE INSIDE CITY LIMITS? YES [x] NO [ ]
f. IS RESIDENCE ON A FARM? YES [ ] NO [x]

3. NAME OF DECEASED (Type or print): First: William Middle: Henry Last: Somes
4. DATE OF DEATH: Month: Sept Day: 17 Year: 1962
5. SEX: male
6. COLOR OR RACE: White
7. MARRIED [x] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: Feb 8, 1900
9. AGE (In years last birthday): 62
IF UNDER 1 YEAR: Months | Days — IF UNDER 24 HRS.: Hours | Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): wood working
10b. KIND OF BUSINESS OR INDUSTRY: Furniture
11. BIRTHPLACE (State or foreign country): Knightsville Ind
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Joseph Somes
14. MOTHER'S MAIDEN NAME: Sarah Walton
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.:
17a. INFORMANT'S NAME: Ruth Warrick Somes
17b. INFORMANT'S ADDRESS: Knightsville Indiana
17c. RELATIONSHIP TO DECEASED: wife

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	MYOCARDIAL INFARCTION	1 day
Conditions, if any, which gave rise to above cause (a) stating the underlying cause last. DUE TO (b)	CORONARY OCCLUSION	?
DUE TO (c)	CORONARY SCLEROSIS	sev. years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).

19. WAS AUTOPSY PERFORMED? YES [ ] NO [x]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
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 [ ] NOT WHILE AT WORK [ ]
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION — COUNTY — STATE

21. ATTENDING PHYSICIAN: I certify that I attended the deceased from 10-31-60 to 9-17-62 and last saw him alive on June 62. Death occurred at A M (C.S.T.) on the date stated above; and to the best of my knowledge, from the causes stated.

22. HEALTH OFFICER: I certify that I investigated cause of death of deceased and find that death occurred at ________ M (C.S.T.) from causes stated and on above date.

23a. Signature of Attending Physician or Health Officer: Robert M. Maurer M.D.
23b. ADDRESS: Brazil, Indiana
23c. DATE SIGNED: 9-19-62

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept 20/62
24c. NAME OF CEMETERY OR CREMATORY: Clearview
24d. LOCATION: Brazil Ind.

DATE REC'D BY LOCAL HEALTH OFFICER: 9-21-62
SIGNATURE OF HEALTH OFFICER: Robert K Webster MD
25. FUNERAL DIRECTOR: Moore & Son ADDRESS: Brazil Ind.

EMBALMER'S NAME: Robert T. Moore
LICENSE No.: 3560
FUNERAL DIRECTOR'S LICENSE No.: 1118

S.B.H.—6-24-3—Revised 1955 U.S. Department Health, Education and Welfare. Form Approved Budget Bureau No. 68-R375