

# MARI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN 22 1960

=60-002198  
STATE FILE NUMBER

Registration District No. 160 Primary Registration District No. 3029 Registrar's No. 6

<b>1. PLACE OF DEATH</b> a. COUNTY <u>JEFF.</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CRYSTAL CITY</u> Length of stay in lb _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>HIGHWAY 61</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Kentucky</u> b. COUNTY <u>MC CRACKEN</u> c. CITY OR TOWN <u>PADUCAH</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>424 HAVAHAN</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>CARL</u> Middle <u>R.</u> Last <u>FUTRELL</u>			<b>4. DATE OF DEATH</b> Month <u>1</u> Day <u>10</u> Year <u>60</u>				
<b>5. SEX</b> <u>MALE</u>	<b>6. COLOR OR RACE</b> <u>WHITE</u>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>9/24/99</u>	<b>9. AGE</b> (last birthday) <u>60</u>	<b>IF UNDER 1 YEAR</b> Months _____ Days _____ <b>IF UNDER 24 HR</b> Hours _____ Min. _____		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done or profession if retired) <u>MAINTENANCE MAN</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>CLUB SAMARA</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>TRIGG CO. KY.</u>			
<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A.</u>		<b>13a. FATHER'S NAME</b> <u>W. R. FUTRELL</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>AUDREY VINSON</u>			
<b>14. NAME OF HUSBAND OR WIFE</b> <u>--</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>709-07-6324</u>			
<b>17. INFORMANT</b> <u>CARL W. FUTRELL</u> Address <u>105 ANN ST. FESTUS MO.</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4° BURNS - ENTIRE BODY -</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	<b>20a. ACCIDENT</b> <input checked="" type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.) <u>Hotel Fire - Deceased trapped</u>					
<b>20c. TIME OF INJURY</b> Hour <u>5:45</u> a.m. Month, Day, Year <u>1-10-60</u>	<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input checked="" type="checkbox"/>						
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Hotel</u>		<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE <u>Crystal City - Jeff. Mo.</u>					
<b>21. I attended the deceased from</b> <u>Inquest</u> , to _____, and last saw her alive on _____ Death occurred at <u>5:45 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> (Degree or title) <u>James A. Johnson M.D.</u>			<b>22b. ADDRESS</b> <u>Festus, Mo.</u>		<b>22c. DATE SIGNED</b> <u>1-14-60</u>		
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>		<b>23b. DATE</b> <u>1/13/60</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>WOODLAWN MEMORIAL</u>		<b>23d. LOCATION</b> (City, town, or county) (State) <u>MC CRACKEN CO. KENTUCKY</u>		
<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>GENTRY R. POLITTE CRYSTAL CITY, MO.</u>		<b>25. DATE RECD. BY LOCAL REG.</b> <u>1-14-60</u>	<b>26. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>				

DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

JAN 25 1938

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Geulney R. Tol

Licensed Embalmer No. 348

P. O. Address Crystal

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.