

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-022487  
STATE FILE NUMBER

FILED JUN 19 1959 Registration District No. 294 Primary Registration District No. 3656 Registrar's No. 127

S. 300  
1-57

1. PLACE OF DEATH a. COUNTY <b>RANDOLPH</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO.</b> b. COUNTY <b>MONROE</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>MOBERLY</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>UNION Twp.</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>COMMUNITY HOSP.</b>		Length of stay in lb <b>1 1/2 DAYS</b>	d. STREET ADDRESS (If outside, give location) <b>12 MI. S.W. OF PARIS</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>EARL B LUTTRELL</b>			4. DATE OF DEATH Month Day Year <b>JUNE 8, 1959</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 14, 1893</b>	9. AGE (In years last birthday) <b>65</b>	IF UNDER 1 YEAR Months Days Hours Min. <b>28 24 - -</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>GENERAL FARMING</b>		11. BIRTHPLACE (City and state or country) <b>MONROE CO., MO.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>HENRY C. LUTTRELL</b>		13b. MOTHER'S MAIDEN NAME <b>FRANCES VICTORIA BOYER</b>		14. NAME OF HUSBAND OR WIFE <b>SALLY G. LUTTRELL</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>489-42-0286</b>		17. INFORMANT Address <b>MRS SALLY G. LUTTRELL</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute circulatory failure</b>					INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Coronary thrombosis = myocardial infarct.</b>					<b>48 hrs</b>
DUE TO (c) <b>arteriosclerosis</b>					<b>not known</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>4261</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.) <b>4261</b>		
20c. TIME OF INJURY Hour a.m. Month, Day, Year p.m.					
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.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <b>8/15</b> <b>8/15</b> <b>pm</b> on <b>8/15</b> <b>pm</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>[Signature]</b>			22b. ADDRESS <b>D. O. 2 109 N 5th, Moberly, Mo.</b>		22c. DATE SIGNED <b>6-11-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>JUNE 9, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>WALNUT GROVE</b>		23d. LOCATION (City, town or county) (State) <b>PARIS, MO.</b>
24. FUNERAL DIRECTOR <b>E. H. AGNEW</b>		ADDRESS <b>PARIS, MO.</b>		25. DATE RECD. BY LOCAL REG. <b>6-8-59</b>	26. REGISTRAR'S SIGNATURE <b>[Signature]</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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

Student .....  
Signature of Student Embalmer

Signed *E. H. Agnew* .....

Licensed Embalmer No. *4000* .....

P. O. Address *Paris, 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.