

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 15178  
Registrar's No. 161

FILED MAY 20 1942  
Registration District No. 660

Primary Registration District No. 4401

1. PLACE OF DEATH:

(a) County Pelliss  
(b) City or town Smithton Mo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution  
In this community 50 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME HENRY G LUGEN

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Clara 6. (c) Age of husband or wife if alive 80 years

7. Birth date of deceased Sept 26 - 1857 (Month) (Day) (Year)

8. AGE: Years 82 Months 6 Days 16 If less than one day hr. min.

9. Birthplace Morgan Co Mo (City, town, or county) (State or foreign country)

10. Usual occupation Shoe repairing

11. Industry or business

MOTHER FATHER { 12. Name John Eugen  
13. Birthplace Germany (City, town, or county) (State or foreign country)  
14. Maiden name Maria  
15. Birthplace Do not know (City, town, or county) (State or foreign country)

16. (a) Informant Earl Eugen

(b) Address 612 E 16th Sedalia Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-14-42 (Month) (Day) (Year)

(c) Place: burial or cremation Smithton Mo

18. (a) Signature of funeral director A. F. Henniger

(b) Address Smithton Mo

19. (a) 4-14-42 (Date received local registrar) (b) Mr Anna Berger (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pelliss  
(c) City or town Smithton (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A. 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 12 year 1942 hour 6-30 minute 0 M.

21. I hereby certify that I attended the deceased from Feb 10 1942 to April 12 1942 and that I last saw him alive on April 10 1942 and that death occurred on the date and hour stated above.

Immediate cause of death urine conu Duration Two  
Due to Arterio Sclerosis

Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_  
Of autopsy none  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? (City or town) (County) (State) \_\_\_\_\_  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? (Specify type of place) (e) Means of injury 0

23. Signature David Boklins (M. D. or other) \_\_\_\_\_  
Address Sedalia Mo Date signed 4-14-42

RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed 5-18-42

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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 \_\_\_\_\_

\_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_,  
working under my personal supervision.

Signed \_\_\_\_\_

*A. F. Nanniger*

Licensed Embalmer No. 3912

P. O. Address Smithton 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 this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 15178

Registration District No. 668

Primary Registration District No. 4401

Registrar's No.

1. PLACE OF DEATH:

- (a) County Pettis  
(b) City or town Smithton  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_ years, months or days)

3. (a) PRINT  
FULL NAME

Henry G. Lugen

3. (b) If veteran,

name war \_\_\_\_\_

3. (c) Social Security

No. \_\_\_\_\_

4. Sex

m

5. Color or  
race

w

6. (a) Single, widowed, married,  
divorced

m

6. (b) Name of husband or wife

6. (c) Age of husband or wife if

alive \_\_\_\_\_ years

7. Birth date of deceased

Sept 26 1858  
(Month) (Day) (Year)

8. AGE:

Years

82

Months

6

Days

If less than one day

min.

9. Birthplace

(City, town, or county)

(State or foreign country)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

(City, town, or county)

(State or foreign country)

14. Maiden name

15. Birthplace

(City, town, or county)

(State or foreign country)

16. (a) Informant

(b) Address

17. (a)

(Burial, cremation, or removal)

(b) Date thereof

(Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a)

(Date received local registrar)

(b)

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH

Month

April

Day

12

year

1942

hour

10

minute

12

M.

21. I hereby certify that I attended the deceased from

\_\_\_\_\_ 19\_\_\_\_

that I have seen him \_\_\_\_\_ live on \_\_\_\_\_ 19\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death

Duration

Coma

Due to

arteriosclerosis

Due to

Hypertension

Other conditions

(Include pregnancy within 3 months of death)

132/2

Major findings

Of operations

Requested information

Of autopsy

PHYSICIAN

Underline  
cause to  
which death  
should be  
charged sta-  
tistically.

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work?

(Specify type of place)

Means of injury

23. Signature

S. G. Delia

(M. D. or other)

Address

Bedford

Date signed

6-6-42

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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