

Dr. Roller

## STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER **9399**

FILED MAR 29 1957

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 112

1. PLACE OF DEATH a. COUNTY <u>Marion</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Marion</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hannibal</u> Inside Limits <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Hannibal</u> <u>0644</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Elizabeth</u> Length of stay in lb		d. STREET ADDRESS <u>415 No. 3rd St.</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Amos</u> Middle <u>Bass</u> Last <u>Lugena</u>			4. DATE OF DEATH <u>3-24-57</u> Month Day Year			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/8/1874</u>	9. AGE (In years last birthday) <u>83</u> 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) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>White Star Lary</u>		11. BIRTHPLACE (City and state or country) <u>Columbia, Mo.</u>		
13. FATHER'S NAME <u>John Lugena</u>			14. MOTHER'S MAIDEN NAME <u>Anna Anderson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Floyd Lygena, Lynwood, California</u> Address		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>Cardiac Degeneration</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>4200</u>			INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) <u>Heavy hypertension probably used</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>		
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.)			
20c. TIME OF INJURY Hour Month, Day, Year a. m. 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 <u>3/10/57</u> to <u>3/24/57</u> and last saw her/him alive on <u>3/24/57</u> . Death occurred at <u>12:45 A.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>M. J. Decker M.D.</u>			22b. ADDRESS <u>Hannibal, Mo.</u>		22c. DATE SIGNED <u>3/27/57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>3/26/57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Grand View Burial Park</u>		23d. LOCATION (City, town, or county) (State) <u>Hannibal, Mo.</u>
24. FUNERAL DIRECTOR <u>J. M. O'Donnell</u> ADDRESS <u>Hannibal, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>3-27-57</u>		26. REGISTRAR'S SIGNATURE <u>Dr. E. M. Luckey by W. C. Fisher</u>	

(Licensed Embalmer's Statement on Reverse Side)

Health, &amp; Welfare Public Service

300 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. securing the medical certification in the same manner as required by law.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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RECEIVED MAR 28 1957  
MARION CO. HEALTH DEPT.  
DATE FILED MAR 28 1957

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 *H M O'Donnell*

Licensed Embalmer No. 3889

P. O. Address Hannibal, 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.