

1938 AUG 20 10:50

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

26713  
Do not use this space.

1. PLACE OF DEATH *107*  
 (a) County *Carroll* Registration District No. *1077*  
 (b) Township *Carroll* Primary Registration District No. *6140* Registered No. *24*  
 (c) City ..... (d) Street No. ....  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.  
 2. PRINT FULL NAME *Marie Cordene Fungado 523*  
 (a) Residence, No. *Summersdale, Mo.* (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *F* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED *Widow*  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Henry Fungado - deceased*  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Nov. 17-1856*  
 7. AGE YEARS *83* MONTHS *7* DAYS *25* If LESS than 1 day, ..... hrs. or ..... min.  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *At home*  
 9. Industry or business in which work was done, as saw mill, bank, etc. *At home*  
 10. Date deceased last worked at this occupation (month and year) ..... 11. Total time (years) spent in this occupation.....

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *7-12 1938*  
 I HEREBY CERTIFY, That I attended deceased from *7-7-1938*, to *7-12-1938*  
 I last saw him alive on *7-12-1938* Death is said to have occurred on the date stated above, at *11 A. m.*  
 The principal cause of death and related causes of importance were as follows:

*Mlecrating Colitis*  
*12 1/2 hrs*  
 Other contributory causes of importance:  
*Mal Nutrition*

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Gasconade Co, Mo*  
 FATHER 13. NAME *Tom. Fred Keubrugge*  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Mo.*  
 MOTHER 15. MAIDEN NAME *Kathleen Keubrugge*  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Don't know*  
 17. INFORMANT (ADDRESS) *Mrs. Tessie Huffman, 2018 Birch Tree, Mo.*

Name of operation ..... Date of .....  
 What test confirmed diagnosis? ..... Was there an autopsy? *Yes*  
 23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? ..... Date of injury .....  
 Where did injury occur? ..... (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

18. BURIAL, CREMATION, OR REMOVAL PLACE *Summersdale* DATE *7-13-1938*  
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) *Dr. J. M. Elloch, Summersdale, Mo.*  
 20. FILED *7/19 1938* *J. M. Daniels, M.D. Local Registrar*

24. Was disease or injury in any way related to occupation of deceased? .....  
 If so, specify .....  
 (Signed) *Dr. J. M. Elloch* M. D.  
 (Address) *Summersdale, Mo.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. AGE should be stated EXACTLY. PHYSICIANS should state CAREFULLY the nature of the injury sustained.

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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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**