

FILLED JUN 13 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

17655

State File No.

Registration District No. 218

Primary Registration District No. 2015 5298

Registrar's No. 54

7000
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Cooper
(b) City or town Boonville, Rural.
(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 all of life. (Specify whether)
years, months or days

3. (a) PRINT FULL NAME Mrs. Anna Torbeck.

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Henry Torbeck 6. (c) Age of husband or wife if alive 65 years
7. Birth date of deceased June 6th 1890
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
50 11 1 _____ hr. _____ min.

9. Birthplace Cooper County, Missouri.
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife.

11. Industry or business At Home.

MOTHER FATHER
12. Name Robert Schwitzky.
13. Birthplace Germany.
(City, town, or county) (State or foreign country)
14. Maiden name Minnie Johnmeyer.
15. Birthplace Germany.
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Henry Torbeck.
(b) Address Boonville, Mo.

17. (a) Burial (b) Date thereof May 9th /41
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Billingsville, Mo.

18. (a) Signature of funeral director Goodman & Boller
(b) Address Goodman & Boller

19. (a) 5-9-41 (b) Dr. [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Cooper 27
(c) City or town Boonville, RURAL. 0
(If outside city or town limits, write "RURAL") 0
(d) Street No. R.F.D. #3
(If rural, give location) 0
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May 28 day 7th.
year 1941 hour 6 minute A.M.

21. I hereby certify that I attended the deceased from May 2
1941 to May 7 1941;
that I last saw her alive on May 4 1941;
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Due to Cerebral failure

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

Major findings:
Of operations _____
Of autopsy _____

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

23. Signature Dr. Mary K Jones (M.D. or other) A.O.
Address 505 1/2 E Spring St Boonville Date signed 5/9/41

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

2022

RECEIVED
District Health Officer No. 8
District File Number
Date Filed 6-11-41

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

J. H. Goodman

Licensed Embalmer No. 1178

P. O. Address *Boonville, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

JAN 3-1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Registration District No. 218

Primary Registration District No. 5298

Registrar's No.

1. PLACE OF DEATH:

(a) County Cooper
(b) City or town Boonville T.P.
(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 Mrs Anna Torbeels

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

4. Sex F 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 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
50 11 1 hr. 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 May day 7
year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that last saw h _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death: Cardiac failure
Due to Acute Endocarditis

Due to Arthritis Deformans
Other conditions (Include pregnancy within 3 months of death)
Major findings: 9.12
Of operations _____
Of autopsy _____

Duration

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 _____

23. Signature Dr. Mary K. Jones (M. D. or other) DO.
Address 505 E. Spring, Boonville, Mo. Date signed 7/21/41

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

SUPPLEMENTAL

S-17655