

No. 2  
17-3815  
X2142

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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 6645

MAR 14 1941

Registration District No. 181

Primary Registration District No. 4107

Registrar's No. \_\_\_\_\_

**1. PLACE OF DEATH:**

(a) County Christian

(b) City or town Billings, 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 \_\_\_\_\_ (Specify whether)

In this community 60 years  
years, months or days

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo (b) County Christian

(c) City or town Billings, Mo.  
(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.

**3. (a) PRINT FULL NAME** Killie Adeline Dorbecker.

3. (b) If veteran, name war No

3. (c) Social Security No. No.

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH:** Month Feb day 24 year 1941 hour 2 minute 23 A.M.

4. Sex Female 5. Color or race W

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

6. (b) Name of husband or wife Fred Dorbecker

6. (c) Age of husband or wife if alive 72 years

7. Birth date of deceased Nov 4 1866  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Apr. 17, 1939, 1939, to Feb. 23, 1941; that I last saw her alive on Feb. 23, 1941; and that death occurred on the date and hour stated above.

**8. AGE:** Years 74 Months 3 Days 20 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Cerebral Apoplexy - Duration 6 days

9. Birthplace Arkansas  
(City, town, or county) (State or foreign country)

Due to High blood pressure  
Chronic bronchitis

Due to Fracture - head of r. femur (1939)

10. Usual occupation Housewife

Other conditions g3W  
(Include pregnancy within 5 months of death)

**MOTHER FATHER**

11. Industry or business Robert Johnson Phillips

12. Name Unknown

13. Birthplace Tennessee  
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

Physician findings: g3W

Of autopsy \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant Paul Lindman

(b) Address Springfield, Mo.

**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? \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof Feb 26, 1941  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rose Hill, Mo.

(Specify type of place) \_\_\_\_\_

While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

18. (a) Signature of funeral director Wallace Fernald

(b) Address Billings, Mo.

19. (a) Feb. 27, 1941 (b) Mrs. Louise Brown  
(Date received local registrar) (Registrar's signature)

23. Signature R. W. Marshall (M. D. or other) J. O.

Address Billings, Mo. Date signed 2/26/41

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

RECEIVED

District Health Officer No. 6;

District File Number 341-350

Date Filed MAR 4 1941

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, by

....., Registered Apprentice No. ....

working under my personal supervision.

Signed

*Andrew Ferbia*

Licensed Embalmer No.

*3649*

P. O. Address

*Billings, 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.