S. No. 2
OM—5-43
V. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 1 1947

Registration District No. 114

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 4186

State File No. 8523

Registrar's No. 3

1. PLACE OF DEATH:

(a) County Franklin

(b) City or town Sullivan
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
North Side Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 13 days (Specify whether
In this community 13 days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County XX

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 4359a Norfolk Ave
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Dora Bell Immekus

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Edward Immekus

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

7. Birth date of deceased May (Month) 24 (Day) 1880 (Year)

8. AGE: Years 66 Months 9 Days 12 If less than one day hr. min.

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

10. Usual occupation At home

11. Industry or business home

FATHER
12. Name Unknown Ferrell
13. Birthplace Unknown (City, town, or county) Unknown (State or foreign country)

MOTHER
14. Maiden name Unknown Dace
15. Birthplace Unknown (City, town, or county) Unknown (State or foreign country)

16. (a) Informant Miss Delpha Immekus
(b) Address 4359a Norfolk Ave. St. Louis.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/9/47 (Month) (Day) (Year)
(c) Place: burial or cremation Anaconda, Mo.

18. (a) Signature of funeral director [signature]
(b) Address Sullivan, Mo.

19. (a) 3-9-47 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 8
year 1947 hour 4.45 a.m. minute M.

21. I hereby certify that I attended the deceased from 2/23/947, 19, to March 8th, 1947
that I last saw her alive on March 8, 1947
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Carcinoma gall bladder	2 1/2 years
Due to	—
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy 46F	

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

23. Signature John McPhail (M. D. or other) M.D.
Address Sullivan Date signed 3/9/47

97 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed 3/31/47

APR 2 1947

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 me

, Registered Apprentice No.

working under my personal supervision.

Signed Robert M Murray

Licensed Embalmer No. 3749

P. O. Address Sullivan, 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, fact should be so stated above.