

FILED AUG 8 1946

Registration District No. **43**

Primary Registration District No. **3007**

1. PLACE OF DEATH:

(a) County **Butler** *Poplar Bluff*
~~Poplar Bluff, Neelyville, Mo.~~
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Poplar Bluff Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: -In hospital or institution **5 days**
In this community **5 days**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Butler**
(c) City or town **Neelyville**
(If outside city or town limits, write "RURAL")
(d) Street No. **1**
(If rural, give location)
(e) Citizen of foreign country? **No.** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **26**
year **1946** hour **5** minute **30** A. M.

21. I hereby certify that I attended the deceased from **July 29**, 19**46** to **July 25**, 19**46**
that last saw her alive on **July 25**, 19**46**
and that death occurred on the date and hour stated above.

Immediate cause of death: **Acute Gastroenteritis 10 days**

Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death) **N**

Major findings: **1190**
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?
While at work? _____ (Specify type of place) _____ (e) Means of injury _____

Signature **Frank E. Dwyer** (M. D. or other) **MD**
Address **Poplar Bluff, Mo** Date signed **7/27/46**

3. (a) PRINT FULL NAME **Rosetta Tracy**

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 **SD**

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: **June 3, 1946**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
1 23 hr. min.

9. Birthplace **Neelyville Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name **Hubert Tracy**

13. Birthplace **Newport, Ark.**
(City, town, or county) (State or foreign country)

14. Maiden name **Anna Mack**

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

16. (a) Informant **Hubert Tracy**

(b) Address **Neelyville, Mo.**

17. (a) **Burial** (b) Date thereof **July 26, 1946**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Neelyville, Mo.**

18. (a) Signature of funeral director **Frank - Cotrell**

(b) Address **Poplar Bluff, Mo.**

19. (a) **8-1-46** (b) **RA Muehle**
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED
District Health Office No. 2,
District File Number 846-948
Date Filed 8-6-46

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.

Not Embalmed

Signed *Lawrence Green*
Licensed Embalmer No. 2964
P. O. Address *Edou Bluff 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. Aug

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

- (a) County Butler
 (b) City or town Poplar Bluff
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Poplar Bluff Hosp.
(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 Rosetta Tracy

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

4. Sex
- ♀
5. Color or race
- C
6. (a) Single, widowed, married, divorced
- S

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
-
- 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)..... (b) Date thereof.....
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation.....

13. (a) Signature of funeral director
- Frank Cottrill

- (b) Address.....

19. (a)
- 8/1/46
- (b)
- D. V. Menetree
-
- (Date received local registrar) (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

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-
- year
- 1946
- hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... to....., 19.....
-
- that I last saw him..... alive on....., 19.....
-
- and that death occurred on the date and hour stated above.
-
- Immediate cause of death.....

Duration

Due to.....

Due to.....

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
 Of operations.....
 Of autopsy.....

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

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 (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..... (M. D. or other).....
-
- Address..... Date signed.....

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

SUPPLEMENTARY

22847