

No. 2  
1-2-43  
17-39  
X33587

FILED FEB 21 1944  
Registered District No. 21844

Primary Registration District No. 3007

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

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: 1  
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Butler  
(c) City or town Poplar Bluff  
(If outside city or town limits, write "RURAL")  
(d) Street No. 724 Garfield  
(If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country..... 0

3. (a) PRINT FULL NAME Carrrie Elizabeth Greshaw

MEDICAL CERTIFICATION

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

20. DATE OF DEATH: Month Jan day 20  
year 1944 hour 11 minute 45 P. M.

4. Sex Female Color or race Col. 6. (a) Single, widowed, married, divorced married

21. I hereby certify that I attended the deceased from Jan 20, 1944 to Jan 20, 1944  
that I last saw h. or alive on Jan 20, 1944  
and that death occurred on the date and hour stated above.

6. (b) Name of husband or wife Wm H Greshaw 6. (c) Age of husband or wife if alive 64 years

Immediate cause of death died suddenly - dead where I saw her  
Due to apoplexy not made  
to cause undetermined

7. Birth date of deceased Jan 2, 1879  
(Month) (Day) (Year)

8. AGE: Years 65 Months 0 Days 18 If less than one day hr. min.

Other conditions (Include pregnancy within 3 months of death)  
Major findings: Of operations  
Of autopsy

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

10. Usual occupation at home

11. Industry or business

12. Name Brown

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

14. Maiden name unknown

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

16. (a) Informant Wm H Greshaw

(b) Address Poplar Bluff Mo

17. (a) Burial (b) Date thereof 1-23-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation city

18. (a) Signature of funeral director Frank Gotrell

(b) Address Poplar Bluff Mo

19. (a) 1-22-44 (b) Belle Steime  
(Date received local registrar) (Registrar's signature)

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 W. H. Greshaw (M. D. or other)  
Address Poplar Bluff Mo Date signed 1/21/44

Duration  
Underline the cause to which death should be charged statistically.

RECEIVED

District Health Office No. 2

District File Number 244-2

Date Filed 2-3-44

FEB 17 1944

**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.....

*George W. Green*

Licensed Embalmer No.....

*2964*

P. O. Address.....

*Poplar Bluff 2*

**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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Feb

Registration District No. 43

Primary Registration District No. 2007

Registrar's No. 34

1. PLACE OF DEATH:  
 (a) County Butler  
 (b) City or town Poplar Bluff  
(If outside city or town limits, file "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)

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 \_\_\_\_\_

3. (a) PRINT FULL NAME Carrie E. Henshaw  
 3. (b) If veteran, name war \_\_\_\_\_  
 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month Jan Day 20  
 Year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
 21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_  
 that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_  
 and that death occurred on the date and hour stated above.  
 Immediate cause of death \_\_\_\_\_

4. Sex F 5. Color or race C 6. (a) Single, widowed, married, divorced Mar  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased Jan 2  
(Month) (Day) (Year)

Due to Coronary Embolism  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)  
 Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

8. AGE: Years 65 Months 0 Days \_\_\_\_\_  
If less than one day \_\_\_\_\_ min.  
 9. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

PHYSICIAN  
 Underline the cause to which death should be charged statistically.  
gfa

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)

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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
 Address \_\_\_\_\_ Date signed \_\_\_\_\_

16. (a) Informant \_\_\_\_\_  
 (b) Address \_\_\_\_\_  
 17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation \_\_\_\_\_  
 18. (a) Signature of funeral director \_\_\_\_\_  
 (b) Address \_\_\_\_\_  
 19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

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

SUPPLEMENTAL

2208