

FILED MAR 5 1948
Registration District No. **283**

Primary Registration District No. **3074**

1. PLACE OF DEATH:

- (a) County **Scott**
(b) City or town **Sikeston**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Sikeston General Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **4 days**
In this community **Life**
years, months or days (Specify whether)

3. (a) PRINT FULL NAME **PAMELA LOUISE ALSUP**

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 **✓**
6. (b) Name of husband or wife **✓**
6. (c) Age of husband or wife if alive **17** years
7. Birth date of deceased **1 17 1948**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
✓ **✓** **4** hr. min.

9. Birthplace **Sikeston MO**
(City, town, or county) (State or foreign country)

10. Usual occupation **✓**

11. Industry or business **✓**

- MOTHER FATHER { 12. Name **Castor Alsups**
13. Birthplace **New Madrid Co MO**
(City, town, or county) (State or foreign country)
14. Maiden name **Mary Jones**
15. Birthplace **Sikeston MO**
(City, town, or county) (State or foreign country)

16. (a) Informant **Castor Alsups**
(b) Address **Sikeston MO**

17. (a) **Burial** (b) Date thereof **1-22-48**
(Burial, cremation, or removal) (Month) (Day) (Year)

- (c) Place: burial or cremation **Memoria Park Cemetery**

18. (a) Signature of funeral director **Walah Funeral Home**
(b) Address **Sikeston MO**

19. (a) **2-20-48** (b) **Mrs. J. J. Henry**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State **MO** (b) County **Scott**
(c) City or town **Sikeston**
(If outside city or town limits, write "RURAL")
(d) Street No. **✓**
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes name country

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month **1** day **22**
year **1948** hour **6:15** minute **P.M.**

21. I hereby certify that I attended the deceased from **1-17-48** to **1-22-48**
that I last saw him alive on **1-22-48**
and that death occurred on the date and hour stated above.

Immediate cause of death

Pneumonia, bronchial -

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 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 **Chas. W. McNamee** (M.D. or other)
Address **Sikeston MO** Date signed **Feb 24 1948**

RECEIVED

District Health Office No. 2,

District File Number 3-48-292

Date Filed 3-2-48

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 Raymond Crews

Licensed Embalmer No. 3467

P. O. Address St. Louis, 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.