

FILED JUL 1 1944

Registration District No. **3063**

Primary Registration District No. **3063**

Registrar's No. **1378**

1. PLACE OF DEATH:

(a) County **St. Louis**
 (b) City or town **Clayton**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
DOA St. Louis Co. Hospital
(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 **Missouri** (b) County **St. Louis**
 (c) City or town **Webster Groves**
(If outside city or town limits, write "RURAL")
 (d) Street No. **909 Bell**
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **George Jessup**

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

4. Sex **M** 5. Color or race **Col.** 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 **May 15, 1944**
(Month) (Day) (Year)

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

9. Birthplace **Clayton, Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name **James Jessup**
 13. Birthplace **Mississippi**
(City, town, or county) (State or foreign country)
 14. Maiden name **Rachel Lawrence**
 15. Birthplace **Mississippi**
(City, town, or county) (State or foreign country)

16. (a) Informant **Rachel Jessup**
 (b) Address **909 Bell, Web. Gro. Mo.**

17. (a) **Burial** (b) Date thereof **6-26-44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Fr. Dickson**

18. (a) Signature of funeral director **J. C. Lewis**

(b) Address **Web. Gro. Mo.**

19. (a) **JUN 29 1944** (b) **E. G. McHarran, M.D.**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **6** day **24**
 year **44** hour **11:22 A.M.** minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
 that I last saw h. _____ alive on _____, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death **Bronchopneumonia**
Impacted dentition

Due to **Whooping cough**

Due to _____

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

Major findings:
 Of operations _____

Of autopsy **Broncho pneumonia**

Duration

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 **H. S. Brynogle, M.D.** Pathologist
(M.D. or other)
 Address **601 Brentwood** Date signed **6/27/44**

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

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.....

not embalmed

Registered Apprentice No.....

working under my personal supervision.

Signed.....

J. Lewis

Licensed Embalmer No.....

2021

P. O. Address.....

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.