

FILED JUN 19 1945
Registration District No. **3**

Primary Registration District No. **55 73**

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

1. PLACE OF DEATH:
 (a) County **Jackson**
 (b) City or town **Grain Valley, Rural**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
2 1/2 Miles South, (Sni A Bar)
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **40 yrs**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **Haborn Jessee**
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Male** 5. Color eye **W** 6. (a) Single, widowed, married, divorced **Widow**
 6. (b) Name of husband or wife **Fannie** 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **Aug 4th 1866**
(Month) (Day) (Year)

8. AGE: Years **78** Months **9** Days **11**
 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business **Farmer**

MOTHER FATHER

12. Name **Andrew Jessee**
 13. Birthplace **Va**
(City, town, or county) (State or foreign country)
 14. Maiden name **Catherine Counts**
 15. Birthplace **Va**
(City, town, or county) (State or foreign country)

16. (a) Informant **Oda Jessée**
 (b) Address **Grain Valley Mo**

17. (a) **Burial** (b) Date thereof **5-17-45**
(Burial, cremation, or other) (Month) (Day) (Year)
 (c) Place: burial or cremation **Perde Chaple, G.V. MO**

18. (a) Signature of funeral director **MRS. G. B. Webb & Son**
Blue Springs Mo
 (b) Address _____

19. (a) **May 18, 1945** (b) **John Lawson**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
Missouri
 (a) State **Missouri** (b) County **Jackson**
 (c) City or town **Grain Valley, Rural**
(If outside city or town limits, write "RURAL")
 (d) Street No. **2 1/2 Mi South**
(If rural, give location)
 (e) Citizen of foreign country? **no** (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **15**
 year **1945** hour **one** minute **25 AM.**
 21. I hereby certify that I attended the deceased from **4-9-** 19**45**, to **5-14-** 19**45**
 that I last saw him alive on **5-14-** 19**45**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage** Duration **48 hr**
 Due to **Essential Hypertension** **15 yrs**
 Due to _____

Other conditions **(none)**
(Include pregnancy within 3 months of death)

Major findings: **(none)**
 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?

23. Signature **W. P. ...** (M. D. or other) **20**
 Address **Independence, Mo** Date signed **5-16-45**
(Specify type of place) (City or town) (State)

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..... *R. Blumb*

Licensed Embalmer No. *2353*

P. O. Address *Blue Springs 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.