MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

26169

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. .....

Township ..... Primary Registration District No. 1003 Registered No. 7837

City St. Louis, Mo (No. City Hospital #2 St. ..... Ward)

2. FULL NAME Harris Holt

(a) Residence. No. 2329a Laclede St., 21 Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: Negro
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Rachel Holts

6. DATE OF BIRTH (MONTH, DAY AND YEAR): 2/27/1891

7. AGE: Years 36 | Months 5 | Days 25 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Porter
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Arkansas

PARENTS

10. NAME OF FATHER: Ike Holt
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Arkansas
12. MAIDEN NAME OF MOTHER: Miss Nash
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Arkansas

14. INFORMANT: Pertella E Sexton
(Address) City Hospital #2

15. FILED ..... 1927 Max C Starvcoff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 8/22 1927

17. I HEREBY CERTIFY, That I attended deceased from 8/21, 1927, to 8/22, 1927 that I last saw him alive on 8/22, 1927, and that death occurred, on the date stated above, at 8:10 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lobar Pneumonia
108
About 1 wk (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) ..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? not known

DID AN OPERATION PRECEDE DEATH? no DATE OF .....

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS? autopsy & clinical

(Signed) [signature], M. D
, 19 (Address) City Hos #2

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Greenwood Cemetery
DATE OF BURIAL: 9/3 1927

20. UNDERTAKER: Dunn Bros
ADDRESS: 215 S. Jefferson av

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.