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

Do not use this space. 6955

1. PLACE OF DEATH

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

Township ..... Primary Registration District No. 1003 Registered No. 1920

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

2. FULL NAME Josh Horton, Jr.

(a) Residence. No. 2021 Olive 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 4 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 9, 1893

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
35	0	10	

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

9. BIRTHPLACE (CITY OR TOWN) ..... (STATE OR COUNTRY) La.

PARENTS

10. NAME OF FATHER: Josh Horton
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTRY) La.
12. MAIDEN NAME OF MOTHER: Anna Green
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTRY) La.

14. INFORMANT: Anna F. Woodard
(Address) City Hospital #2

15. FILED ..... 19 Max C. Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 19, 1928

17. I HEREBY CERTIFY, That I attended deceased from 2/15, 1928, to Feb. 19, 1928, that I last saw him alive on 2/19, 1928, and that death occurred, on the date stated above, at 8:55 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lobar Pneumonia
108
about 10 (duration) yrs. mos. 5 ds.

CONTRIBUTORY (SECONDARY) 101 (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? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) L. S. Howell, M. D.
, 19 (Address) City Hosp. #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: Jefferson Barracks — DATE OF BURIAL: 2-25-1928

20. UNDERTAKER: W. S. Wade Mdl. Co. — ADDRESS 4202 Finney

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.