

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

Do not use this space.

27631

1. PLACE OF DEATH

County Jackson
Township Kan
City Kansas City

Registration District No. 399

Primary Registration District No. 1002

File No. 3313
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Horton Infant
(a) Residence. No. 5204 W 4th St. St. 81 Ward.

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>8-3-1929</u>		
7. AGE	YEARS	MONTHS
		DAYS
		If LESS than 1 day, <u>2</u> hrs. or <u>2.0</u> min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Baby</u> (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer		

9. BIRTHPLACE (CITY OR TOWN) K.C. Mo
(STATE OR COUNTRY)

PARENTS	10. NAME OF FATHER <u>Truman W. Horton</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) <u>Ell.</u> (STATE OR COUNTRY)
	12. MAIDEN NAME OF MOTHER <u>Beulah May Kelsey</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) <u>Chamberburg</u> (STATE OR COUNTRY)

14. INFORMANT Truman W. Horton
(Address) 204 W 4th St K.C. Mo.

15. FILED 8-2-29 M M Crowe
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8-3-1929

17. I HEREBY CERTIFY, That I attended deceased from 8-2-1929, to 8-3-1929, that I last saw him alive on 8-3-1929, and that death occurred, on the date stated above, at 12:50 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Prematurity
15/10/10 (duration) yrs. mos. ds.

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

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH _____
DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
WAS THERE AN AUTOPSY? _____
WHAT TEST CONFIRMED DIAGNOSIS
(Signed) J. H. Bennett, M.D.
8-2-29 (Address) East 8th St.

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 <u>Mt Hope</u>	DATE OF BURIAL <u>8-3-1929</u>
20. UNDERTAKER <u>Geo. H. Long</u>	ADDRESS <u>K.C. Mo</u>

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.

STATE OF MISSOURI, WITH UNFADING INK—THIS IS A PERMANENT RECORD

