

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

Do not use this space.

✓ 12977

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **St. Louis** (No. **2315 N 10 St**)

File No.....
Registered No. **3260**
St. Ward)

2. FULL NAME

Nicholas Ketzner

(a) Residence. No. St. **26** Ward.

(Usual place of abode)

(If nonresident give city or town and State)

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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Single

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

Single

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

March 13-1885

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
40	0	20	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **Landscape Gardener**

(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) **Missouri**

10. NAME OF FATHER

Thomas Ketzner

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) **Germany**

12. MAIDEN NAME OF MOTHER

Katherine Wilson

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) **Germany**

14. INFORMANT

Lena Ketzner

(Address) **2315 N. 10 St**

15. FILED

APR -1 1927 **Mar. 6** **St. Louis**

REGISTERED

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **April 3rd 1927**

17.

I HEREBY CERTIFY, That I attended deceased from **April 1st**, 1927, to **April 2nd**, 1927, that I last saw him alive on **April 2nd**, 1927, and that death occurred, on the date stated above, at **9 a.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar Pneumonia

CONTRIBUTORY (SECONDARY)

108 (duration) **4** yrs. **0** mos. **0** ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH? **NO** DATE OF.....

WAS THERE AN AUTOPSY? **NO**

WHAT TEST CONFIRMED DIAGNOSIS? **General Post**

(Signed) **Goldman W. Wilson**, M. D.

April 4, 1927 (Address) **2504 N. 14th 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

DATE OF BURIAL

Jefferson City, Mo

4/5 1927

20. URBETAKER

ADDRESS

Arthur J. Donnelly **2039 Wash St**

At 2. 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.

14 of 12000
/ Pm

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County.....

Registration District No. 791

File No.....

Township.....

Primary Registration District No. 1003

Registered No. 3260

City St. Louis St. Ward)

2. FULL NAME

Nicholas Kitzner

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

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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S (write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 13 - 1885

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
42 0 20

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (duration) yrs. mos. ds.
(b) General nature of industry, business, or establishment in which employed (or employer) (duration) yrs. mos. ds.
(c) Name of employer

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

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14.

INFORMANT (Address)

15.

FILED 502-9 May 6 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 3 1927

17. I HEREBY CERTIFY, That I attended deceased from 19....., 19..... that I last saw h..... alive on 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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)....., M. D. , 19 (Address)

*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 DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-12977