

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

Do not use this space.

35592

1. PLACE OF DEATH

County.....
Township.....
City..... *St. Louis*

Registration District No. *791*
Primary Registration District No. *1903*
(No. *7137 Idaho Ave*)

File No.....
Registered No. *10362*
St. Ward)

2. FULL NAME

Louis Frank Petzold

(a) Residence, No. St., Ward.
(Usual place of abode)

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

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *July 13, 1865*

7. AGE YEARS MONTHS DAYS If LESS than I day, hrs. or min.
64 3 6

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) *Carroll Park*
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *Saxon*
(STATE OR COUNTRY) *Germany*

10. NAME OF FATHER *Carl Petzold*

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

12. MAIDEN NAME OF MOTHER *Katharina Schumann*

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

14. INFORMANT *Minnie Petzold*
(Address) *7137 Idaho Ave*

15. *Oct 22 1929*
FILED *Max C. Fowler* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Oct 19 1929*

17. I HEREBY CERTIFY That I attended deceased from *Oct 2 1928*, 1928, to *Oct 19 1929*, 1929 that I last saw him alive on *Oct 8 1929*, 1929, and that death occurred, on the date stated above, at *St. Louis*.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Parenchymatous Nephritis
131

CONTRIBUTORY (SECONDARY) *1290*

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH..... DATE OF.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) *Edward Rebla*, M. D.

Oct 21 1929 (Address) *7310 Michigan Ave*

*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

St. Trinity Lutheran

10/22 1929

20. UNDERTAKER

ADDRESS

C. Hoffmeister & Co. 7814 So. Broadway

Every item of information 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.

