

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

Do not use this space.

12568
3095

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... Primary Registration District No. 1003
 City..... St. Louis (No. Alexian Bros Hospital St. Ward)

2. FULL NAME Arnold Tuschschmidt

(a) Residence. No. 6040 Waterman St. Ward. 5
 (Usual place of abode) (If nonresident give city or town and State)

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.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan - 1858

7. AGE YEARS MONTHS DAYS **IF LESS than 1 day, hrs. or min.**
abt. 76 Unknown

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Accountant
 (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)
Switzerland

10. NAME OF FATHER Jacob Tuschschmidt

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

12. MAIDEN NAME OF MOTHER Anna Huber

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

14. INFORMANT Rosa Tuschschmidt
 (Address) 6040 Waterman St

15. FILED 12 17 1929
Mary C. Stover REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3 - 11 - 1929

17. I HEREBY CERTIFY That I attended deceased from Jan 3, 1925, to March 11, 1929
 that I last saw him alive on March 9, 1929, and that death occurred, on the date stated above, at 7 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
hem. Intestinal Hemorrhage
131
11.3 (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) Obese & Senescent
 (duration) yrs. mos. da.

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) Wm. R. ... M. D.
3/11 1929 (Address) 3600 B. Blvd. Bld

*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 to obary **DATE OF BURIAL** 3-14 1929

20. UNDERTAKER Arthur J. Donnelly **ADDRESS** 2039 Wood St

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.

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3600 J. Grand - f

Pr 2740

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