

REGISTRATION DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS APR 18 1960

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-60-014485

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Cape Girardeau				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before a. STATE Mo. b. COUNTY Cape Girardeau)			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Applecreek		Length of stay in 1b 41 Yrs.		c. CITY OR TOWN Oak Ridge		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Oak Ridge			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) Oak Ridge R		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Albert Middle W. Last Tuschhoff				4. DATE OF DEATH Month April Day 9 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10-15-1881	9. AGE (last birthday) 78	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (City and state or country) Friedheim, Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Henry Tuschhoff			13b. MOTHER'S MAIDEN NAME Bertina Keseke			14. NAME OF HUSBAND OR WIFE Mary Tuschhoff	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT Elmer Tuschhoff Jackson, Mo.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO (b) Hypertensive arteriosclerotic Cardiovascular disease DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH 3 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)					
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ s.m. _____ p.m. _____							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from 20th 1954 to 6 April 1960 and last saw him/her alive on April 6, 1960 Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE J. H. Trolinger, M.D. (Degree or title)				22b. ADDRESS J. H. TROLINGER, M. D. JACKSON, MISSOURI		22c. DATE SIGNED 4/12/60	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		23b. DATE 4-12-60		23c. NAME OF CEMETERY OR CREMATORY Sargents Chapel		23d. LOCATION (City, town, or county) (State) Sedgewickville Mo.	
24. FUNERAL DIRECTOR G.C. Brauhaft ADDRESS Jackson, Mo.			25. DATE RECD. BY LOCAL REG. 4-16-1960		26. REGISTRAR'S SIGNATURE Drew Kaster		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

MAY 18 1960

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. 43

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.