DEPARTMENT OF HEALTH
DIVISION OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH
County Cuyahoga Registration District No. 392 File No. 27556
Township ____ Primary Registration District No. 8187 Registered No. 1846
or Village ____ No. St Francis Hospital St., ____ Ward
or City of Cleveland (If death occured in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Teresa Kirchenschlager Did Deceased Serve in U.S. Navy or Army ____
(a) Residence. No. 261 Hubbell Ave Ward ____ (If nonresident give city or town and State)
(Usual place of abode)
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: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed or Divorced (write the word): Widow

5a If married, widowed or divorced HUSBAND of (or) WIFE of Jacob F. Kirchenschlager

6 DATE OF BIRTH (month, day, and year) March 24-1853

7 AGE: Years 76 | Months 0 | Days 17 | If LESS than 1 day ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of Industry, business, or establishment in which employed (or employer) ____
(c) Name of employer ____

9 BIRTHPLACE (city or town) Athens Co.
(State or country) Ohio

PARENTS
10 NAME OF FATHER Lewis
11 BIRTHPLACE OF FATHER (city or town) Dont Know
(State or country)
12 MAIDEN NAME OF MOTHER Dont Know
13 BIRTHPLACE OF MOTHER (city or town) Dont Know
(State or country)

14 Informant Mrs Nymph Good
(Address) 261 Hubbell St

15 Filed 4/8, 1929 J. J. Regan REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) April 6 1929

17 I HEREBY CERTIFY, That I attended deceased from April 5 1929 to Apr 6 1929
that I last saw h. alive on Apr 6 1929
and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:
Intestinal Obstruction
(duration) ____ yrs. ____ mos. 7 ds.
CONTRIBUTORY (SECONDARY) Carcinoma of Sigmoid
more than (duration) ____ yrs. 3 mos. ____ ds.

18 Where was disease contracted if not at place of death? ____
Did an operation precede death? Yes Date of Apr 5. 1929
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Charles H Davey M. D.
Apr 8, 1929 (Address) St Francis Hosp

*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. (See reverse side for additional space.)

19 PLACE of Burial, Cremation, or Removal Greenlawn Cem | DATE OF BURIAL 4-8-1929
20 UNDERTAKER Keenan & Donahue | ADDRESS Cle
20a WAS THE BODY EMBALMED? Yes | EMBALMER'S LICENSE NO. 1755

should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Quellenangabe:
"Ohio, United States Aufzeichnungen," Aufnahmen, FamilySearch (https://www.familysearch.org/ark:/61903/3:1:33S7-957W-SF7Y?view=index : 2. Mai 2025), Aufnahme 2250 von 3243; Ohio Historical Society (Columbus, Ohio).
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