

FILED FEB 18 1944
Registration District No. _____

Primary Registration District No. 6076

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Lemay
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Mt. St. Rose Sanatorium
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 26 hrs.
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Franklin
(c) City or town Coella
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME AMIL FRED TUTTAS

3. (b) If veteran, name war None 3. (c) Social Security No. Unknown

4. Sex MALE 5. Color or race W 6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife Ethel Tuttas 6. (c) Age of husband or wife if alive 33 years
7. Birth date of deceased May 23 1907
(Month) (Day) (Year)

8. AGE: Years 36 Months 8 Days 20 If less than one day
hr. _____ min.

9. Birthplace Duquoin Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Miner

11. Industry or business _____

MOTHER FATHER { 12. Name Michael Tuttas
13. Birthplace Unknown Germany
(City, town, or county) (State or foreign country)
14. Maiden name Anna Graesicki
15. Birthplace Unknown Poland
(City, town, or county) (State or foreign country)

16. (a) Informant Ethel Tuttas
(b) Address Coella, Illinois
17. (a) Removal (b) Date thereof 2-15-44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Duquoin, Illinois

18. (a) Signature of funeral director Albert H. Hoppe, Inc.
(b) Address 4700 Washington Blvd.

19. (a) FEB 15 1944 (b) C. G. McFarlan, M.D.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 13
year 1944 hour 6 minute 30 P.M.

21. I hereby certify that I attended the deceased from 2-12-
1944, to 2-13, 1944
that I last saw him alive on 2-13-, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis
Duration 2 yrs

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy 1321

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place)
(e) Means of injury 0

23. Signature John C. Murphy (M. D. or other) M.D.
Address 7101 S. Broadway Date signed 2/13/44

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

366
8/84

NOV 15 1944

1945

111 6 111

MAR 8 1944

FEB 18 1944

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
.....; Registered Apprentice No.....
working under my personal supervision.

Signed..... *E. W. Wilkins*

Licensed Embalmer No..... *3575*

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 this body is not embalmed, fact should be so stated above.