

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **38985**
Registrar's No. **9627**

FILED NOV 18 1955

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 9627			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois				b. COUNTY Madison	
b. CITY (If outside corporate limits, write RURAL and give town or township) St. Louis, Mo.		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN Alton		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL				e. STREET ADDRESS (If rural, give location) 219 Allen				§1208	
3. NAME OF DECEASED (Type or Print) a. (First) Fred			b. (Middle) William		c. (Last) Tutt		4. DATE OF DEATH (Month) (Day) (Year) November 3, 1955		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Feb. 3, 1908		9. AGE (In years last birthday) (If under 1 year: Months) (If under 24 hrs.: Hours) (Min.) 47	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Salesman			10b. KIND OF BUSINESS OR INDUSTRY Fuller Brush Co.			11. BIRTHPLACE (City and State or Foreign Country) Belboz, N.D.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME Herman Tutt			13b. MOTHER'S MAIDEN NAME Catherine Beck			14. NAME OF HUSBAND OR WIFE Adeline			
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. Unknown		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Adeline Tutt, 219 Allen, Alton, Ill.				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> DUE TO (b) Tuberculosis of left kidney DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i> Diabetes mellitus						INTERVAL BETWEEN ONSET AND DEATH 6 mos. sev yrs. sev yrs.	
19a. DATE OF OPERATION Jan 1954		19b. MAJOR FINDINGS OF OPERATION Tuberculosis of right kidney						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Alton, Ill.		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____			
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 016x							
22. I hereby certify that I attended the deceased from October 26, 1955 , to November 3, 1955 , that I last saw the deceased alive on November 3, 1955 , and that death occurred at 11:30 Am. , from the causes and on the date stated above.									
22a. SIGNATURE (Degree or title) Theodore J. Fuller M.D.				23b. ADDRESS BARNES HOSPITAL			23c. DATE SIGNED 11/3/55		
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 11-4-55		24c. NAME OF CEMETERY OR CREMATORY Elmwood Cemetery		24d. LOCATION (City, town, or county) (State) Litchfield, Ill.			
DATE REC'D BY LOCAL REG. NOV 4 1955		REGISTRAR'S SIGNATURE J. Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Smith Funeral Homes, 2521 Edwards			Alton, Ill.		

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

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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....

F. 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.