

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

RECEIVED OCT 15 1953

33902

State File No. \_\_\_\_\_  
1003 Registrar's No. 8993

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Franklin</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Clair</u>	
c. LENGTH OF STAY (In this place) <u>9 days</u>		d. STREET ADDRESS (If rural, give location) <u>Rt # 1</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>St. Louis Children's Hosp.</u>			

3. NAME OF DECEASED a. (First) <u>William</u> b. (Middle) <u>Carl</u> c. (Last) <u>Protte</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>9 - 16 - 53</u>		
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDDED, DIVORCED (Specify) <u>None</u>	
8. DATE OF BIRTH <u>9-26-45</u>		9. AGE (In years last birthday) <u>8</u> Months <u>8</u> Days <u>22</u>		10. IF UNDER 1 YEAR Hours <u>8</u> Min. <u>22</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>St. Louis, Missouri</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					

13a. FATHER'S NAME <u>William R. Protte</u>		13b. MOTHER'S MAIDEN NAME <u>Agnese Wild</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Johnston 600 S. Kings Highway</u>	

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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Diffuse encephalomalacia</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>coma</u> DUE TO (c) <u>Idiopathic epilepsy</u>			INTERVAL BETWEEN ONSET AND DEATH
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		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) <u>332 X</u>	
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?	

22. I hereby certify that I attended the deceased from 9-8, 1953, to 9-16, 1953, that I last saw the deceased alive on 9-16, 1953, and that death occurred at 9:30 A.M., from the causes and on the date stated above.

23a. SIGNATURE (Name or title) <u>Dr. L. Johnston M.D.</u>		23b. ADDRESS <u>St. Louis, Childrens Hosp.</u>		23c. DATE SIGNED <u>9-17-53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>9-17, 53</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Local</u>	
		24d. LOCATION (City, town, or county) (State) <u>St. Clair Mo.</u>			

DATE REC'D BY LOCAL REG. <u>SEP 17 1953</u>		REGISTRAR'S SIGNATURE <u>J. Earl Smith M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Albert H. Hoppe 4700 Washington.</u>	
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E.P. (Licensed Embalmer's Statement on Reverse Side)

OCT 21 1953

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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 .....  
Student Embalmer

Signed

*Paul A. Wachtel*

Licensed Embalmer No.

*4787*

P. O. Address

*St. Louis, Mo.*

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.