

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-003750  
STATE FILE NUMBER

FILED JAN 26 1959 Registration District No. 317 Primary Registration District No. 541 Registrar's No. 136

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>U. City Mo. Clayton</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>U. City</b> <b>4336</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>D.O.A. County Hosp.</b>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <b>7823 Delmar</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Wm.</b> Middle <b>K.</b> Last <b>Protzman</b>			4. DATE OF DEATH Month <b>Jan.</b> Day <b>13</b> Year <b>1959</b>		
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5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan 17 1907</b>	9. AGE (In years last birthday) <b>51</b>	IF UNDER 1 YEAR Months <b>11</b> Days <b>26</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Real Estate</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Protzman R.E. Co.</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Wm. L. Protzman</b>	13b. MOTHER'S MAIDEN NAME <b>Marie Kansteiner</b>	14. NAME OF HUSBAND OR WIFE <b>June R. Protzman</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT <b>Mrs. Wm K. Protzman</b>	Address <b>7823 Delmar</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carbon monoxide poisoning</b>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>Self inhaled carbon monoxide - body found in car</b>
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20c. TIME OF INJURY <b>4:40</b>	Hour <b>4:40</b> Month <b>1</b> Day <b>13</b> Year <b>1959</b>	<b>Body found</b>
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>car in basement garage</b>	20f. CITY, TOWN, OR LOCATION <b>University City</b>	COUNTY <b>St. Louis</b>	STATE <b>Missouri</b>
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21. I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_  
Death occurred at \_\_\_\_\_ on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>John C. Murphy</i>	(Degree or title) <b>Coroner</b>	22b. ADDRESS <b>Clayton, Mo.</b>	22c. DATE SIGNED <b>1/16/59</b>
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23a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Cremation</b>	23b. DATE <b>1-14-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>O.G. Crem.</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis Mo</b>
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24. FUNERAL DIRECTOR <b>C. R. Lupton and Sons</b>	ADDRESS <b>7233 Delmar U. City Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>1-14-59</b>	26. REGISTRAR'S SIGNATURE <i>John C. Murphy</i>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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

*Arnold W. Schoene*

Licensed Embalmer No. *3864*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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