

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-046768

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318**
FILED DEC 21 1961

Primary Registration District No. **1003**

Registrar's No. **11690**

STATE FILE NUMBER

AMENDED

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis Mo.		Length of stay in 1b since birth	c. CITY OR TOWN St. Louis. Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION 2518 Montgomery Str.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) 2518 Montgomery Str. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First ALVINA Middle PROTTE Last			4. DATE OF DEATH Month Dec. Day 14th. Year 1961			
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Sept. 4, 1901	9. AGE (last birthday) 60	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY XXXXXXXX		11. BIRTHPLACE (City and state or country) St. Louis Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Sickle		13b. MOTHER'S MAIDEN NAME Ida Hays		14. NAME OF HUSBAND OR WIFE Rudolph Protte		

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. Ida Hays	17. INFORMANT Rudolph Protte, Husband, 2518 Montgomery Str
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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) Bronchial asthma		INTERVAL BETWEEN ONSET AND DEATH 241x
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) Arteriosclerotic heart disease		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
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20c. TIME OF INJURY Hour 6:00 A a.m. p.m.	Month, Day, Year
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION St. Louis	COUNTY St. Louis	STATE Mo.
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21. I attended the deceased from **July 16, 1958** to **Dec. 14, 1961** and last saw her **alive on Dec. 13, 1961**
 Death occurred at **6:00 A** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Henry C. Westerman, M.D.	22b. ADDRESS 2136 East Grand Blvd	22c. DATE SIGNED 12-15-61
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Dec. 16, 1961	23c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cemetery	23d. LOCATION (City, town or county) (State) Lindbergh & St. Charles Mo.
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24. FUNERAL DIRECTOR Henry Leidner Und. Co	ADDRESS 2223 St. Louis Ave	25. DATE RECD. BY LOCAL REG. DEC 15 1961	26. REGISTRAR'S SIGNATURE Paul Smith, M.D.
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DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

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

Albert Mayfield

Licensed Embalmer No.

3077

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.