S. No. 2
M—5-43
5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 12 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 31171

Registration District No. 274 Primary Registration District No. 5932 Registrar's No. 247

1. PLACE OF DEATH:

(a) County Pettis

(b) City or town ~~LaMont~~ RURAL La Monte
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St[redacted]
[redacted]
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution None (Specify whether
In this community Unknown
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Unknown 000

(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")

(d) Street No. 4381 Penrose Avenue 9
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 1

If yes, name country No

3. (a) PRINT FULL NAME Sgt Albert E Schob 37 415 242

3. (b) If veteran, name war World War II

3. (c) Social Security No. -

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced Single 0

6. (b) Name of husband or wife - -

6. (c) Age of husband or wife if alive - years

7. Birth date of deceased November (Month) 5 (Day) 1923 (Year)

8. AGE: Years 21 Months 10 Days 15 If less than one day - hr. - min.

9. Birthplace St. Louis (City, town, or county) Missouri 0 (State or foreign country)

10. Usual occupation Soldier

11. Industry or business U. S. Army

FATHER
12. Name Albert W. Schob
13. Birthplace Unknown (City, town, or county) Unknown 0 (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) Unknown 0 (State or foreign country)

16. (a) Informant U. S. Army Records
(b) Address Sedalia AAFld, Warrensburg, Mo

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 9-22-45 (Month) (Day) (Year)
(c) Place: burial or cremation St Louis, Mo

18. (a) Signature of funeral director Geo Dillard
(b) Address Sedalia, Missouri

19. (a) 9-21-45 (Date received local registrar) (b) A. G. Campbell (Registrar's signature)

1486

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 20
year 1945 hour 0345 minute A M.

21. I hereby certify that I attended the deceased from 0400 hours 20 September 1945 to 0400 - 20 Sept 1945; that I last saw him alive on Never, 19__; and that death occurred on the date and hour stated above.

Immediate cause of death Shock, traumatic

Due to ruptured liver.

MAJOR FINDINGS OF AUTOPSY: 1-Fracture complete, transverse axillary line, 3rd, 5th, & 6th, left, thoracic ribs. 2-Wound, lacerated upper left peritoneum. 3-Wound, greatly lacerated, involving upper 3rd of right & left lobes of liver extending through entire substance of the liver, & involving ½ of the inferior venacava.

Duration

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) Accident 80

(b) Date of occurrence 20 September 1945

(c) Where did injury occur 6 miles east Knobnoster, Mo. (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? 6 miles east Knobnoser, Missouri (Specify type of place)

While at work? No (e) Means of injury Auto Accident

23. Signature Dr. K. L. Holden coroner (~~M.D.~~ or other) D.O.

Address 329 Ilgenfritz Bldg. Sedalia, Mo. Date signed 9/21/45

(Licensed Embalmer's Statement on Reverse Side)

10-10-45

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 L. E. Boulelin

Licensed Embalmer No. 3867

P. O. Address Scotia N.Y.

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.

. S. No. 2B
0M—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 0ct

Registration District No. 274 Primary Registration District No. 5932 Registrar's No. 247

1. PLACE OF DEATH:

(a) County Pettis

(b) City or town Rural La monte Twp
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(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 Albert E Schab

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Nov 5 1920
(Month) (Day) (Year)

8. AGE: Years 21 Months 10 Days 17 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace
(City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace
(City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: (Month) (Day) (Year) 20
year hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19;
that I last saw him alive on 19;
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Due to	
Due to crushed under car	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

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?
(Specify type of place)

While at work? (e) Means of injury auto truck collision

23. Signature W. F. L. Wohlem (M. D. or other) D.D.

Address 3k-9 Igenfritz Bldg. Date signed 10/16/45
Sedalia Mo.

SUPPLEMENTARY

31171