OCT 29 1930

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

30421

1. PLACE OF DEATH
County Lincoln
Township Bedford
City Near Troy (No. ..... St. ..... Ward)

Registration District No. 491
Primary Registration District No. 56524

File No. ..... see other certificate
Registered No. 38

2. FULL NAME Emma Starkey

(a) Residence. No. ..... St. ..... Ward. .....
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 29/1897

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
33	2	27	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY) Lincoln Co

PARENTS

10. NAME OF FATHER Charles Schroeder
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Germany
12. MAIDEN NAME OF MOTHER Julia M Weisbrod
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Marthasville
(STATE OR COUNTRY) Mo. Warren Co.

14. INFORMANT .....
(Address)

15. FILED 9/26, 1930 W P Smith REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept. 25 1930

17. I HEREBY CERTIFY, That I attended deceased from Sept. 23, 1930, to Sept. 25, 1930, that I last saw her alive on Sept. 25, 1930, and that death occurred, on the date stated above, at 2:20 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumonia
see supplement

..... (duration) ..... yrs. ..... mos. 9 ds.

CONTRIBUTORY (SECONDARY) Congestion in Lungs
..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED At Home
IF NOT AT PLACE OF DEATH Lincoln Co. Mo.
DID AN OPERATION PRECEDE DEATH? No DATE OF ✓
WAS THERE AN AUTOPSY? ✓
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) J. E. Schroeder M. D.
Sept. 25, 1930 (Address) Troy, Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Wright City Cemetery
DATE OF BURIAL: Sept 26 1930

20. UNDERTAKER: Kemper Bros
ADDRESS: Troy Mo

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. AGE should be stated EXACTLY. PHYSICIANS should state

Dr. W. P. Smith,
Troy, Missouri.

Dear Doctor Smith;-

We have two death certificates in our office of Emma Starkey, who died Sept. 25, 1930, signed by you as Local Registrar. One certificate has the medical information signed by J. E. Schroeder, D. C. of Troy, Mo. and signed by you Sept. 26, 1930, the other is signed by W. S. Clarenbach, M.D. Wright City, Missouri, signed by you Nov. 17, 1930. Please inform us which is the legal certificate.

Kindly give this your prompt attention, as it is very important that we have this information. Enclosed is a stamped envelope for your reply.

Very respectfully,

James Stewart
James Stewart, M. D.
State Registrar.

Troy Mo Apr 25th 1932

Dear Dr Stewart

In reply to above inquiry beg leave to say that the certificate signed by Dr. W.S. Clarenbach is the legal certificate, the one signed by Schroeder was filed immediately after the death and on it I issued a burial permit, his diagnosis was undoubtedly an error made for a purpose and I finally got Dr Clarenbach's certificate. Yours Truly W. P. Smith

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1. PLACE OF DEATH

County: Lincoln — Registration District No.: 491 — File No.:

Township: — Primary Registration District No.: 5654 — Registered No.: 38

City: Near Troy (No. ..... St. ..... Ward)

2. FULL NAME Emma Starkey

(a) Residence. No. ..... St., ... Ward. (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR): June 29 - 1897

7. AGE: 38 YEARS — MONTHS: 2 — DAYS: 27 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Lincoln Co. Mo

PARENTS

10. NAME OF FATHER: Chas Schroeder

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Germany

12. MAIDEN NAME OF MOTHER: Julia M Weyhrod

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Marthasville Mo

INFORMANT (Address):

FILED Nov 17, 1930 — W. P. Smith, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Sept 25 1930

17. I HEREBY CERTIFY, That I attended deceased from Jan 8th 1927, 1930 to Sept 25th, 1930 that I last saw her alive on Sept 25th, 1930, and that death occurred, on the date stated above, at about 11:30 A.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Tuberculosis of the Lungs

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY)

(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? —

DID AN OPERATION PRECEDE DEATH? No. DATE OF —

WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS? Microscopic examination of Sputum

(Signed) W. S. Clarenbach, M. D.

11/14, 1930 (Address) Wright City Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL — DATE OF BURIAL 19

20. UNDERTAKER — ADDRESS

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No.....; .....St. .....Ward)

2. FULL NAME .....

(a) Residence. No..... St., ...Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14.
INFORMANT .....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17.
I HEREBY CERTIFY, That I attended deceased from .....
....., 19....., to ....., 19.....
that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

S-30421-2

.....(duration).....yrs. .....mos.....ds

CONTRIBUTORY .....
(SECONDARY)

.....(duration).....yrs. .....mos.....ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) ....., M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.