

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

Do not use this space.

26680

**1. PLACE OF DEATH**

County Jackson Registration District No. 399  
Township Raw Primary Registration District No. 1002  
City H.C. Mo. St. Audens Hosp.  
"Starn"

File No. \_\_\_\_\_  
Registered No. 3281  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Rose Pearl Starn  
(a) Residence. No. 1421 Charlotte 2 Ward. (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

Fr.

4. COLOR OR RACE

Wh.

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)

May - 10 - 1900

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

30

1

28

8. OCCUPATION OF DECEASED

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

Laundress

(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)

Mo.

10. NAME OF FATHER

Stephen Evers

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Mo.

12. MAIDEN NAME OF MOTHER

Mary Wilber

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Mo.

14.

INFORMANT

(Address)

E. M. Starn  
1421 Charlotte

15.

FILED

8/8 30 M. M. Crowe

Asst. REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8-8-1930

17. I HEREBY CERTIFY, That I attended deceased from Aug 1st, 1930, to Aug 8, 1930, that I last saw her alive on August 7, 1930, and that death occurred, on the date stated above at 2 m.

THE CAUSE OF DEATH\* was AS FOLLOWS:

Surgical shock following cholecystectomy

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 1 ds.

CONTRIBUTORY (SECONDARY)

Cholecystitis

(duration) 1 yrs. 6 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

surgical shock

(Signed)

O. M. Jensen, M. D.

8/8 30 (Address) 19 E 4 Front Ave

\*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

DATE OF BURIAL

Maple Hill Cem.

8-8-30

20. UNDERTAKER

ADDRESS

O. U. Marx

1915 E 15

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.

