

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

Do not use this space.

**1. PLACE OF DEATH**

County Jackson  
Township Ray  
City Kansas City Mo. (No. St. Vincent's Hosp)

Registration District No. 880  
Primary Registration District No. 147

File No. 1035  
Registered No. 20  
St. \_\_\_\_\_ Ward)

**2. FULL NAME**

(a) Residence, No. 2400 Holmes 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** Single (write the word)

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

**6. DATE OF BIRTH (MONTH, DAY AND YEAR)** Jan. 2 - 1930

**7. AGE** YEARS MONTHS DAYS If LESS than 1 day, ... hrs. or ... min. 6 46 a

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Infant  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

**9. BIRTHPLACE (CITY OR TOWN)** Kansas City Missouri  
(STATE OR COUNTRY)

**10. NAME OF FATHER** Louis Butterfield

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)** St. Joseph Missouri  
(STATE OR COUNTRY)

**12. MAIDEN NAME OF MOTHER** Catherine Quinlan

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

**14. INFORMANT** W. E. Quinlan  
(Address) 2807 Belmont

**15. FILED** Jan 3, 1930 M. M. Crowe  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** 1/2/30 19

**17. I HEREBY CERTIFY, That I attended deceased from** 1/2/30 **19**  
**19**, to 1/2/30 **19**  
that I last saw h. \_\_\_\_\_ alive on 1/2/30 **19**, and that death occurred, on the date stated above, at 6:46 a m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Prematurity  
(7 mo)  
(duration) yrs. mos. ds.

**CONTRIBUTORY (SECONDARY)** 164 W  
(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? Cremated  
(Signed) Joseph H. Walker M. D.

(Address) 915 Griggs

\*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** St Mary Cemetery **DATE OF BURIAL** Jan 3 1930

**20. UNDERTAKER** J. A. Harrison ADDRESS 2512 Belmont

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.

RECORD

