APR 28 1930

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

Do not use this space.

File No. 8395

Registered No. 246

1. PLACE OF DEATH

County: Greene — Registration District No.: 318

Township: ... — Primary Registration District No.: 2004

City: Springfield (No. 2000 W. Phelps St. Ward)

2. FULL NAME: Rosco Ray Minor

(a) Residence. No. 2000 W. Phelps St., Ward. (If nonresident give city or town and State)
(Usual place of abode)

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: male

4. COLOR OR RACE: W

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Nov. 16 1917

7. AGE: Years 12 | Months 4 | Days 6 | If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: child student
(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

PARENTS

10. NAME OF FATHER: Frank Minor

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

12. MAIDEN NAME OF MOTHER: Elsie Shallow

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

14. INFORMANT: Mrs Frank Shallow
(Address): 2000 W. Phelps

15. FILED 3-24, 1930 Lon Sharp REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 3-22 1930

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to 3-22, 1930, that I last saw h. alive on 3-22, 1930, and that death occurred, on the date stated above, at 4 PM m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Epilepsy
(duration) 9 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? Clinical
(Signed) D. F. Freeman, M. D.
3-23, 1930 (Address) Springfield 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: Fair Grove Mo. | DATE OF BURIAL: 3-24-1930

20. UNDERTAKER: [illegible] | ADDRESS: [illegible]

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.