LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

1 PLACE OF DEATH

County Greene

Township ..... Registration District No. 318 File No. 39170

or

Village ..... Primary Registration District No. 2001 Registered No. 823

or

City Springfield Mo. (NO. 770 College St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Virgil Theodore Jours Jr.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: White

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Child

6 DATE OF BIRTH: Oct. 15 (Month) (Day) 1917 (Year)

7 AGE: 1 yrs. ..... mos. 20 ..... If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: ——
(b) General nature of industry business or establishment in which employed (or employer): ——

9 BIRTHPLACE (City or town, State or foreign country): Mo.

PARENTS

10 NAME OF FATHER: Virgil Jours

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Mo.

12 MAIDEN NAME OF MOTHER: Mabel Garrison

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Texas

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Virgil Jours

(Address) 770 College

15 Filed NOV 8 1918 Edwin F. James Registrar
Dollie B. Johnson Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Nov. 7 (Month) (Day) 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from July 1, 1918, to Nov. 7, 1918, that I last saw him alive on Nov. 7, 1918, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Dysentery 14
136

(Duration) about yrs. 5 mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Mathews M. D.

Nov. 8, 1918 (Address) Springfield Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Linden Cem.

DATE OF BURIAL: 10-8, 1918

20 UNDERTAKER: Bentz Lund Co.

ADDRESS: Walnut & Market

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ... St.; ..... Ward)

(If death oc
hospital or
give its NAM
of street and

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH

..... (Month) ..... (Day), 1..... (Year)

7 AGE .....yrs.....mos.....ds.

If LESS than 1 day,.....hrs. or.....min.?

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

9 BIRTHPLACE
(City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER
(City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

..... (Month) ..... (Day), 19

17 I HEREBY CERTIFY, that I attended deceas

....., 191....., to ....., 1

that I last saw h.....alive on ....., 1

and that death occurred, on the date stated above, at.....

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration).....yrs.....mos.....

CONTRIBUTORY .....
(Secondary)

..... (Duration).....yrs.....mos.....

(Signed) .....

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Cau
(1) Means of Injury; and (2) whether Accidental, Suicidal or Hor

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Tra
or Recent Residents)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL | **DATE OF BURIAL** ....., 1

20 UNDERTAKER | **ADDRESS**