

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

PLACE OF DEATH
County Stone
Township Cass
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 648 File No. 19256
Primary Registration District No. 611 Registered No. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME Isaac Jagua

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RADE white SINGLE MARRIED Single WIDOWED OR DIVORCED
(Write the word)

DATE OF BIRTH 12-18-1912
(Month) (Day) (Year)

AGE 5 yrs. 8 mos. 8 ds. If LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION (a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) x

BIRTHPLACE (City or town, State or foreign country) Schal Mo R#1

PARENTS
NAME OF FATHER Fred Jagua
BIRTHPLACE OF FATHER (City or town, State or foreign country) Mo.
MAIDEN NAME OF MOTHER Minnie Jenkins
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jas Wright
(ADDRESS) Schal Mo R#1

Filed 5/26 1912
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 5 26, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from May 25, 1912, to May 26, 1912, that I last saw him alive on May 26, 1912, and that death occurred, on the date stated above, at 2:30 p.m.

The CAUSE OF DEATH* was as follows:
Infantile Paralysis

16 (Duration) yrs. _____ mos. _____ ds.

Contributory (SECONDARY) _____
(Signed) E. E. Wade M. D.
8527 1912 (Address) Cheser Mo.

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

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 _____

PLACE OF BURIAL OR REMOVAL Amberlin Cmty DATE OF BURIAL 5/27 1912
UNDERTAKER B. F. Nickle ADDRESS Cheser

WRITE PLAINLY, WITH BOLDING INK—FILLS IN NECESSARY

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.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Colton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc. of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*

Whooping cough; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

WRITE PLAINLY. UNFAIR TO BE A PERM. IT IS A PERM. ANENT B. 1. 6D

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

PLACE OF DEATH

County Stone
Township Cass
or
Village
or
City _____ (NO. _____ St. _____ Ward _____)

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

Registration District No. 648 File No. 19256
Primary Registration District No. 6111 Registered No. _____

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

FULL NAME Isaac Jagua

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX m COLOR OR RACE w SINGLE MARRIED WIDOWED OR DIVORCED S
DATE OF BIRTH Dec. 18, 1911
(Month) (Day) (Year)
AGE 5 yrs. 8 mos. 8 ds. If LESS than 1 day, hrs. or min.
OCCUPATION (a) Trade, profession, or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer)

DATE OF DEATH May 26, 1912
(Month) (Day) (Year)
I HEREBY CERTIFY, that I attended deceased from May 26, 1912, to May 26, 1912, that I last saw alive on May 26, 1912, and that death occurred, on the date stated above, at 2:30 p.m.

The CAUSE OF DEATH* was as follows:
Infantile Paralysis
(Duration) _____ yrs. _____ mos. _____ ds.

BIRTHPLACE (City or town, State or foreign country) School Mo. R. #1
PARENTS
NAME OF FATHER Fred Jagua
BIRTHPLACE OF FATHER (City or town, State or foreign country) Mo.
MAIDEN NAME OF MOTHER Margie Jenkins
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mo.

Contributory (SECONDARY) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) O. E. Wade M. D.
May 26, 1912 (Address) Oliver

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jas. Wright
(ADDRESS) School Mo. R. #1

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

Filed June 1, 1912 J. E. Cox REGISTRAR

PLACE OF BURIAL OR REMOVAL Kimberlin Cem DATE OF BURIAL May 27, 1912
UNDERTAKER B. F. Wick ADDRESS Oliver

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

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