

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-009880

STATE FILE NUMBER

FILED APR 1 1959 Registration District No. 156 Primary Registration District No. 2001 Registrar's No. 163

1. PLACE OF DEATH a. COUNTY Jasper		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Oklahoma b. COUNTY Ottawa	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Joplin		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Wyandotte
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Freeman		Length of stay in 1b 3 weeks	d. STREET ADDRESS (If outside, give location) None
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last Joe N. Kagey			4. DATE OF DEATH Month Day Year March 16, 1959		
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5. SEX Male <input checked="" type="checkbox"/>	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 5, 1890	9. AGE (In years from birthday) 68	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Indian Service	10b. KIND OF BUSINESS OR INDUSTRY Teacher	11. BIRTHPLACE (City and state or country) Unknown, Va.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME G.H. Kagey	13b. MOTHER'S MAIDEN NAME Anna Moyers	14. NAME OF HUSBAND OR WIFE Aline H. Kagey
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, go, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Mrs. Aline H. Kagey	Address Wyandotte, Oklahoma
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH 332X
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Arteriosclerosis</u>	
	DUE TO (c) _____	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Myocardia, Diabetes Mellitus, Bilateral Pyelonephritis, Prostatic Hypert.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from <u>2-21-59</u> to <u>3-16-59</u> and last saw her alive on <u>3-16-59</u> Death occurred at <u>6:30 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>M. Walker</u> (Degree or title) <u>M.D.</u>	22b. ADDRESS <u>Med. Arts Bldg. Joplin Mo.</u>	22c. DATE SIGNED <u>3-20-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE March 19, 1959	23c. NAME OF CEMETERY OR CREMATORY Fairland, Oklahoma	23d. LOCATION (City, town, or county) (State) Fairland, Oklahoma
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24. FUNERAL DIRECTOR Cooper Funeral Home	ADDRESS Miami, Oklahoma	25. DATE RECD. BY LOCAL REG. 3-26-1959	26. REGISTRAR'S SIGNATURE <u>Doyle Merriam</u>
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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

1959

APR 17

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Robert C. Keller*

Licensed Embalmer No. *5062*

P. O. Address *Joplin, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.