

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
 FILED VS SEP 17 1959

59-033386

Registration District No. 294 Primary Registration District No. 3006 Registrar's No. 199

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Randolph</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Randolph</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Moberly</u>		Length of stay in 1b <u>3 1/2 hours</u>		c. CITY OR TOWN <u>Moberly</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Woodland Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>KFD # 2</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>OPAL PEARL DESKIN</u>				4. DATE OF DEATH Month Day Year <u>Sept - 8 - 1959</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>5-22-06</u>	9. AGE (last birthday) <u>53</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (City and state or country) <u>Randolph Co. Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>John W. Given</u>			13b. MOTHER'S MAIDEN NAME <u>Cynthia Ann Nichols</u>		14. NAME OF HUSBAND OR WIFE <u>Estel Deskin</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. W. E. Deskin Moberly Mo.</u>			
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>Acute posterior myocardial infarction.</u> DUE TO (b) <u>Hypertensive cardiovascular disease.</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>18 hrs.</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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.)					
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.								
20d. INJURY OCCURRED WHILE AT WORK <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	
21. I attended the deceased from <u>Sept. 8, 1959</u> to <u>Sept. 8, 1959</u> and last saw her <u>alive</u> on <u>Sept. 8, 1959</u> Death occurred at <u>12:15</u> <u>P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>Will Fleming, M.D.</u>			22b. ADDRESS <u>Moberly, Mo.</u>			22c. DATE SIGNED <u>9-9-59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county)		(State)		
<u>Burial</u>	<u>Sept-10-1959</u>	<u>Oakland Cemetery</u>		<u>Moberly Mo.</u>				
25. FUNERAL DIRECTOR <u>Cater Funeral Home Moberly Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>9-10-59</u>		26. REGISTRAR'S SIGNATURE <u>Leah Blaine</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed R. M. Carter

Licensed Embalmer No. 4117

: P. O. Address Moberly Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.