

JRL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH  
FILED VS UCI 9 1960

=60-035442

STATE FILE NUMBER

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 178

|  |   |   |  |   |  |   |   |
|--|---|---|--|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Livingston</b>   |   |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>e. STATE <b>Missouri</b> b. COUNTY <b>Livingston</b> |  |   |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWN <b>Chillicothe</b>   |   | Length of stay in 1b<br><b>46 yrs</b>   |  | c. CITY OR TOWN <b>Chillicothe</b>  |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>1721 Clay St.</b>  |   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location)<br><b>1721 Clay St.</b>   |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>THEODORE WILLIAM ISRAEL</b>   |   |   |  | 4. DATE OF DEATH<br>Month Day Year<br><b>Sept. 20, 1960</b>   |  |   |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>  | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>1/19/87</b>  | 9. AGE (last birthday)<br><b>73</b>  | IF UNDER 1 YEAR<br>Months Days  | IF UNDER 24 HR<br>Hours Min.              |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Farmer</b>   |   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own farm</b>                                 |   | 11. BIRTHPLACE (City and state or country)<br><b>Livingston Co., Mo.</b>   |   | 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b> |
| 13a. FATHER'S NAME<br><b>John Israel</b>   |   |   | 13b. MOTHER'S MAIDEN NAME<br><b>Bell Fairchild</b>                                   |   |  | 14. NAME OF HUSBAND OR WIFE<br><b>Honor Israel</b>                                    |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>  |   | 16. SOCIAL SECURITY NO.<br><b>441-09-5181</b>   |  | 17. INFORMANT Address<br><b>Mrs. Honor Israel, Chillicothe, Mo.</b>   |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Squamous Cell Carcinoma of right parotid gland</b>  |   |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 years</b>                                    |   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b)<br>DUE TO (c)   |   |   |  |   |  |   |   |
| 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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |   |   |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour a.m. p.m.<br>Month, Day, Year  |   |   |  |   |  |   |   |
| 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>June 1959</u> to <u>Sept. 20, 1960</u> and last saw him alive on <u>Sept. 20, 1960</u><br>Death occurred at <u>10:30P</u> on the date stated above, and to the best of my knowledge, from the causes stated. |   |   |  |   |  |   |   |
| 22a. SIGNATURE (Degree or title)<br><b>William T. Fair, MD</b>   |   |   |  | 22b. ADDRESS<br><b>Chillicothe, Mo.</b>   |  |   | 22c. DATE SIGNED<br><b>9/24/60</b>        |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  | 23b. DATE   | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City, town, or county) (State)   |  |   |   |
| <b>Burial</b>  | <b>Sept. 23, 1960</b>   | <b>Edgewood cemetery</b>  |  | <b>Chillicothe, Mo.</b>   |  |   |   |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Donald Gordon, Chillicothe, Mo.</b>   |   |   |  | 25. DATE RECD. BY LOCAL REG.<br><b>Sept. 20, 1960</b>   | 26. REGISTRAR'S SIGNATURE<br><b>Annalee Taylor</b>   |   |   |

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 Richard W. Bandall

Licensed Embalmer No. 4866

P. O. Address Phillips

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.