

FILED AUG 16 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

28670

STATE FILE NUMBER

Registration District No.

182

Primary Registration District No.

4298

Registrar's No.

26

1. PLACE OF DEATH a. COUNTY <b>Linn</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Linn</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR <b>Browning</b> TOWN		c. CITY OR <b>Purdin</b> TOWN	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If outside, give location)	
3. NAME OF DECEASED (Type or print) First <b>Etta</b> Middle <b>Lydia</b> Last <b>Cady</b>		4. DATE OF DEATH Month <b>8</b> Day <b>4</b> Year <b>57</b>	
5. SEX <b>Fe</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 25, 1877</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (City and state or country) <b>Missouri</b>	
13a. FATHER'S NAME <b>Thomas Pulliam</b>		14. NAME OF HUSBAND OR WIFE <b>David L. Cady</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT <b>Mrs. Stella Mae Gooch Browning,</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intestinal Obstruction</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Strangulated Hernia</b> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>48 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>5615</b>		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 _____ a.m. _____ p.m. Month, Day, Year _____			
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
21. I attended the deceased from <b>Aug 2, 1957</b> to <b>Aug 4, 1957</b> and last saw her alive on <b>Aug 4, 1957</b> Death occurred at <b>8 a</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>L.R. Martin</b> (Degree or title) <b>m. d.</b>		22b. ADDRESS <b>Browning Mo</b>	
22c. DATE SIGNED			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>806-57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Purdin Cem</b>	23d. LOCATION (City, town, or county) (State) <b>Purdin Mo.</b>
24. FUNERAL DIRECTOR <b>Wade Funeral Home</b> ADDRESS <b>Browning,</b>		25. DATE RECD. BY LOCAL REG. <b>8-9-1957</b>	
		26. REGISTRAR'S SIGNATURE <b>Mrs. R. Kelley</b>	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

1961 6 2 100

### 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 Gerald I. Wade

Licensed Embalmer No. 417  
P. O. Address Brown

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.