

OREGON STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

1 PLACE OF DEATH
 County Polk State Oregon State Registered No. 32
 Local Registered No. 32
 Township _____ or Village _____ or
 City Dallas No. _____, St. _____ Ward _____
 (If death occurred in a hospital or institution, give its name instead of street and number)

2 FULL NAME William Benjamin Seeley
 (a) Residence No. Uglow Ave. St. _____
 (Usual place of abode) (If nonresident, give city or town and state)
 Length of residence in city or town where death occurred 2 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced
 HUSBAND of Belle Seeley
 (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 20, 1959

7 AGE Years Months Days If less than 1 day, hrs. or min.
61 2 7

8 OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Farmer
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9 BIRTHPLACE (city or town) Black River
 (State or country) Wisconsin

10 NAME OF FATHER William H. Seeley

11 BIRTHPLACE OF FATHER (city or town) Unknown
 (State or country) U.S.

12 MAIDEN NAME OF MOTHER Maria Miller

18 BIRTHPLACE OF MOTHER (city or town) Unknown
 (State or country) New York

14 Informant Belle Seeley
 (Address) Dallas, Oregon

15 Filed April 29, 1920 B.H. McCallon
 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April, 27, 1920

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1, 1920 to April 27, 1920, that I last saw him alive on March 1, 1920, and that death occurred on the date stated above, at 7.15 P. m.

The CAUSE OF DEATH* was as follows:
Hemiplegia
 (duration) 1 yrs., _____ mos., _____ days.

CONTRIBUTORY (Secondary)
 (duration) _____ yrs., _____ mos., _____ days.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis? clinical
 (Signed) B.H. McCallon, M. D.
April, 1920 (Address) Dallas Ore

* State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Albany, Ore DATE OF BURIAL May, 1, 1920

20 UNDERTAKER R. L. Chapman, ADDRESS Dallas, Ore

Seeley