

MARGIN RESERVED FOR BINDING

FORM VS-2

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY ITEM OF INFORMATION SHOULD BE CAREFULLY SUPPLIED. AGE SHOULD BE STATED EXACTLY. PHYSICIANS SHOULD STATE CAUSE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT.

STATE PRINTING

STANDARD CERTIFICATE OF DEATH

9022

LOCAL REGISTRAR'S NUMBER 127

STATE OF OREGON  
BOARD OF HEALTH—PORTLAND  
U. S. PUBLIC HEALTH SERVICE

STATE FILE NO.

DATE RECEIVED  
SEP 12 1955

1. NAME OF DECEASED (TYPE OR PRINT)			a. (First) Hazel			b. (Middle) M.			c. (Last) Seeley		
2. PLACE OF DEATH						3. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
A. COUNTY Benton						A. STATE Oregon B. COUNTY Benton					
B. CITY (If outside corporate limits, write RURAL location) OR TOWN Corvallis						C. CITY (If outside corporate limits, write RURAL) OR TOWN Corvallis					
C. LENGTH OF STAY (in this place) 5 years						D. STREET (If rural, give location) ADDRESS 147 N 11th St.					
D. FULL NAME OF HOSPITAL OR INSTITUTION 147 N 11th St.						D. STREET (If rural, give location) ADDRESS 147 N 11th St.					
4. DATE OF DEATH			5. SEX			6. COLOR OR RACE			7A. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, SEPARATED		
8 25 1955			F			W			Never Married		
7B. NAME OF HUSBAND OR WIFE			8. DATE OF BIRTH			9. AGE (In years last birthday)			10. BIRTHPLACE (State or foreign country)		
none			12/30/1888			66			St. Paul Nebraska		
11. CITIZEN OF WHAT COUNTRY?			12. FATHER'S NAME			13. MOTHER'S MAIDEN NAME			14. USUAL OCCUPATION		
U.S.			Horace G. Seeley			Margenia Welsh			none		
14b. KIND OF BUSINESS OR INDUSTRY			15. IF VETERAN, NAME WAR			16. INFORMANT'S OWN SIGNATURE			17. SOCIAL SECURITY NO.		
Home			no			Son Darday for Mrs. G. V. Coburn			none		
17. SOCIAL SECURITY NO. none						MEDICAL CERTIFICATION ENTER ONLY ONE CAUSE PER LINE FOR (A), (B), AND (C)					
18. CAUSE OF DEATH						I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (A) Cardiovascular disease					
* This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.						ANTECEDENT CAUSES					
						DUE TO (B) Hypertension					
						DUE TO (C) Decomposition					
19A. DATE OF OPERATION						19B. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY?			21A. ACCIDENT SUICIDE HOMICIDE (Specify)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office building, forest, etc.)			21C. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21D. TIME OF INJURY			21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?			22. I HEREBY CERTIFY THAT I ATTENDED THE DECEASED FROM 1/10/55, 19 8/25/55, 19 THAT I LAST SAW THE DECEASED ALIVE ON 8/25, 1955, AND THAT DEATH OCCURRED AT 11:45 P.M., FROM THE CAUSES AND ON THE DATE STATED ABOVE.		
			WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>								
23A. SIGNATURE			23B. ADDRESS			23C. DATE SIGNED					
Wendell Ball M.D.			Mt. Corvallis, Oregon			8/29/55					
24A. BURIAL, CREMATION, REMOVAL (Specify)			24B. DATE			24C. NAME OF CEMETERY OR CREMATORY			24D. LOCATION (City, town, or county) (State)		
Cremation			8/30/1955			Mt. Crest Abbey			Salem Marion Oregon		
DATE REC'D BY LOCAL REG.			REGISTRAR'S SIGNATURE			25. FUNERAL DIRECTOR'S SIGNATURE			ADDRESS		
8-29-55			Gather Ennes, Dep.			D. Durdan			361 Corvallis, OR Oregon		

Seeley