

80a STATE OF OREGON 896

1. PLACE OF DEATH:

(a) County Multnomah
(b) City or town Portland
(If outside city or town limits write RURAL)
(c) Name of hospital or institution St. Vincent Hospital
(If not in hospital or institution write street number or location)
(d) Length of stay: In hospital or institution 4 days
In this community 50 yrs. In state 50 yrs.
Specify whether years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Oregon (b) County Multnomah
(c) City or town Portland
(If outside city or town limits write RURAL)
(d) Street No. 7555 N. Denver
(If rural give location)
(e) If foreign born, how long in U. S. A.? 50 years.

3. (a) FULL NAME Mathilda Seely

3. (b) If veteran, name war _____ 3. (c) Social Security No. None

4. Sex F 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Jack Seely 6. (c) Age of husband or wife 58 years
if alive 24 years

7. Birth date of deceased July 24 1884
(Month) (Day) (Year)

8. AGE: Years 56 Months 10 Days 24
If less than one day hr. min.

9. Birthplace Denmark
(City, town, or county) (State or foreign country)

10. Usual occupation housewife

11. Industry or business _____

12. Name Hans Christensen

13. Birthplace Denmark
(City, town, or county) (State or foreign country)

14. Maiden name No record

15. Birthplace Denmark
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature M.D. Rose

(b) Address 537 S. Alder

17. (a) Burial (b) Date thereof 6/20/41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Riverview Cem.

18. (a) Signature of funeral director A. J. Rose & Son

(b) Address 537 S. E. Alder

19. (c) 150 JUN 19 1941 (b) Adolph Weingart, M.D.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. Date of death: Month June day 18
year 1941 hour 3 minute 30 A.M.

21. I hereby certify that I attended the deceased from _____
19____, to _____, 19____; that I last saw h_____ alive
on _____, 19____; and that death occurred on the date
and hour stated above.

Immediate cause of death Ruptured Duration _____
Brain abscess &
meningitis.

Due to _____
Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Mastoiditis
Of operations Right.

Of autopsy as above

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place,
in public place? _____
(Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature Strom C. Colman (M. D. or other) M.D.
Address Shelling Bldg Date signed 6/18/41

Seeley