

**OREGON STATE BOARD OF HEALTH
CERTIFICATE OF DEATH**

V 1709

1 PLACE OF DEATH County Mult. State Ore. State Registered No. _____ Local Registered No. 196
 Township _____ or Village _____ or
 City Portland No. Waverly Baby Home St. Ward _____
 (If death occurred in a hospital or institution, give its name instead of street and number)
 2 FULL NAME Dloyd Cecil Seely
 (a) Residence. No. _____ St., _____
 (Usual place of abode) (If nonresident, give city or town and state)
 Length of residence in city or town where death occurred: yrs. 6 mos. 10 ds. How long in U. S., if of foreign birth? yrs. _____ mos. _____ ds. _____

PERSONAL AND STATISTICAL PARTICULARS

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

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

6 DATE OF BIRTH (month, day, and year) Nov. 19-1918

AGE	Years	Months	Days	If less than 1 day, hrs. or min.
		<u>6</u>	<u>16</u>	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

BIRTHPLACE (city or town) Portland (State or country) Ore.

10 NAME OF FATHER _____

11 BIRTHPLACE OF FATHER (city or town) _____ (State or country) _____

12 MAIDEN NAME OF MOTHER _____

13 BIRTHPLACE OF MOTHER (city or town) _____ (State or country) _____

4 Informant Anna Patricia Seely (Address) 1214 Woodward Ave

5 Filed 5/28, 1919 Garrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 1919

17 I HEREBY CERTIFY, That I attended deceased from Nov 29, 1918, to May 26, 1919, that I last saw him alive on May 26, 1919, and that death occurred on the date stated above, at 2:45 P m.

The CAUSE OF DEATH * was as follows _____

Septicemia (Dysnoia Type)

(duration) _____ yrs., _____ mos., 14 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? Organisms cultured from blood
 (Signed) H. G. Palmer, M. D.

May 27, 1919 (Address) 1011 Corbett Bldg

* 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

River View Cemetery

DATE OF BURIAL

May 28 1919

20 UNDERTAKER

J. P. Finley & Son

ADDRESS

Mult. at 5

Seeley