2946

Oregon State Board of Health
Division of Vital Statistics

Standard Certificate of Death
STATE OF OREGON 131a

State File No. ....
Local Registrar's No. **2948**

1. PLACE OF DEATH:

(a) County ___Multnomah___

(b) City or town ~~Hospital~~ Por7land
(If outside city or town limits write RURAL)

(c) Name of hospital or institution: ___Multnomah Hospital___
(If not in hospital or institution write street number or location)

(d) Length of stay: In hospital or institution ___Since 8-5-44___
(Specify whether)
In this community ___50 yrs.___ l in state ___Life___
years, months or days)
Gaston

3. (a) FULL NAME ___George G. Seely___

3. (b) If veteran, name war ___none___

3. (c) Social Security No. ___none___

4. Sex ___Male___ | **5. Color or race** ___White___ | **6. (a)** Single, widowed, married, divorced ___Married___

6. (b) Name of husband or wife ___Eva___ | 6. (c) Age of husband or wife if alive ___75___ years

7. Birth date of deceased ___July 31, 1866___
(Month) (Day) (Year)

8. Age: Years ___78___ | Months ___0___ | Days ___16___ | If less than one day ___hr. ___ min.

9. Birthplace ___Lane Co. Oregon___
(City, town, or county) (State or foreign country)

10. Usual occupation ___Old Age Pensioner___

11. Industry or business ___Retired Sawyer, Inman-Poulsen Lbr.Co.___

Father { 12. Name ___Jira Seely___
{ 13. Birthplace ___Unknown___ (City, town, or county) (State or foreign country)

Mother { 14. Maiden name ___Emily unknown___
{ 15. Birthplace ___Oregon___ (City, town, or county) (State or foreign country)

16. (a) Informant's own signature ___Hosp.Records & Mrs.Lenora Miller___

(b) Address ___924 S. W. 16th Ave.___

17. (a) ___Cremation___ (b) Date thereof ___8/21/44___
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation ___Riverview Abbey Crematorium___

18. (a) Signature of funeral director ___Miller & Tracey___ C.W.Tanner #8

(b) Address ___714 S.W. 20th Place___

19. (a) ___AUG 19 1944___
(Date received local registrar)

(Registrar's signature) ___Thos.S...eador M.D.___

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2. USUAL RESIDENCE OF DECEASED:

(a) State ___Oregon___ (b) County ___Mult.___

(c) City or town ___Portland___
(If outside city or town limits write RURAL)

(d) Street No. ___1612 S. E. 35th Place___
(If rural give location)

(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. Date of death: Month ___August___ day ___17___
year ___1944___ hour ___1:30 p.m.___ minute ___

21. I hereby certify that I attended the deceased from ___8-5___,
19__44__, to ___8-17___, 19__44__; that I last saw h__im__ alive
on ___8-17___, 19__44__; and that death occurred on the date
and hour stated above.

	Duration
Immediate cause of death ___Uremia___ Hypostatic Pneumonia	
Due to ___H.C.V.D.___ Arteriolar Nephrosclerosis	
Due to ___	
Other conditions (Include pregnancy within 3 months of death) ___Exogenous Obesity___	**PHYSICIAN** Underline the cause to which death should be charged statistically
Major findings: Of operations ___	
Of autopsy ___Pneumonia - HCVD - Arteriolar Nephrosclerosis___	

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? ___
While at work? ___ (Specify type of place)
(e) Means of injury ___

Signature ___Carl F. Holm___ (M. D. or other) M.D.
Address ___Mult. Hospital___ Date signed ___8-19-44___