

OREGON STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

105

1 PLACE OF DEATH
 County Seaton State Oregon State Registered No. 105
 Township _____ or Village _____ or _____
 City Alsea No. Home in Alsea St. _____ Ward _____
 (If death occurred in a hospital or institution, give its name instead of street and number)

2 FULL NAME Estlin Myrtle Seely
 (a) Residence. No. Alsea St. _____
 (Usual place of abode) (If nonresident, give city or town and state)
 Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>F</u>	4 COLOR OR RACE <u>White</u>	5 Single, Married, Widowed, or Divorced (write the word) <u>Single</u>	
5a If married, widowed, or divorced HUSBAND of (or) WIFE of _____			
6 DATE OF BIRTH (month, day, and year) <u>Jan 23 - 1888</u>			
7 AGE	Years <u>40</u>	Months <u>6</u>	Days <u>7</u>
	If less than 1 day, hrs. or min. _____		
8 OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Housekeeper</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____ (c) Name of employer _____			
9 BIRTHPLACE (city or town) <u>Illinois</u> (State or country)			
PARENTS	10 NAME OF FATHER <u>Wm. Seely</u>		
	11 BIRTHPLACE OF FATHER (city or town) <u>Illinois</u> (State or country)		
	12 MAIDEN NAME OF MOTHER <u>Elizabeth Jones</u>		
13 BIRTHPLACE OF MOTHER (city or town) <u>Illinois</u> (State or country)			
14 Informant <u>Mrs. S. N. Starfield</u> (Address) <u>Corvallis</u>			
15 Filed <u>Aug 5, 1920</u> <u>C. H. Newth</u> Registrar			

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30 1920

17 I HEREBY CERTIFY, That I attended deceased from 7-17-20, 19____, to 7-30-20, 19____, that I last saw her alive on 7-17-20, 19____, and that death occurred on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:
Pneumonia Tuberculosis

 _____ (duration) Acute 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? Laboratory
 (Signed) Harry Anderson M. D.
8-2-20 (Address) Marconi Bldg, Corvallis

* 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 <u>Alsea</u>	DATE OF BURIAL <u>8/10 1920</u>
20 UNDERTAKER <u>McBover</u>	ADDRESS <u>Corvallis Ore</u>

Seely