

OREGON STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

89

1 PLACE OF DEATH
County Deschutes State Oregon Local Registered No. 79
Township _____ or Village _____ or
City Corvallis No. _____ St. _____ Ward _____
(If death occurred in a hospital or institution, give its name instead of street and number)
2 FULL NAME Elizabeth Hardschuberg
(a) Residence, No. Corvallis St. _____ (If nonresident, give city or town and state)
(Usual place of abode)
Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PARENTS. See instructions on back of certificate. Exact statement of OCCUPATION.

PERSONAL AND STATISTICAL PARTICULARS
3 SEX F 4 COLOR OR RACE White 5 Single, Married, Widowed or Divorced (write the word) Married
6a If married, widowed or divorced HUSBAND of Wm Hardschuberg (or) WIFE of _____
6 DATE OF BIRTH (month, day, and year) July 8, 1876
7 AGE Years 48 Months 1 Days 15 If less than 1 day, hrs. or min.
8 OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work at home (b) General nature of industry, business, or establishment in which employed (or employer) _____ (c) Name of employer _____
9 BIRTHPLACE (city or town) Iowa (State or country)
10 NAME OF FATHER John Harsingoen
11 BIRTHPLACE OF FATHER (city or town) Iowa (State or country)
12 MAIDEN NAME OF MOTHER Mrs Mc Clam
13 BIRTHPLACE OF MOTHER (city or town) Iowa (State or country)
14 Informant Wm Hardschuberg (Address) Corvallis
15 Filed Sept 5, 1924 Bernice Lane Registrar

MEDICAL CERTIFICATE OF DEATH
16 DATE OF DEATH (month, day, and year) Aug 23 1924
17 I HEREBY CERTIFY, That I attended deceased from Aug 22, 1924, to _____, 19____, that I last saw him alive on Aug 22, 19____, and that death occurred on the date stated above, at _____ M.
The CAUSE OF DEATH* was as follows: Cerebral thrombosis at base
(duration) _____ yrs. mos. 3 days.
CONTRIBUTORY High blood pressure (Secondary) _____ (duration) _____ yrs. mos. _____ days.
18 Where was disease contracted if not at place of death? No
Did an operation precede death? No Date of _____
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) J. J. Jones M. D.
Sept 2, 1924 (Address) Corvallis Ore
* 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 Newton Cemetery DATE OF BURIAL 8/25 1924
20 UNDERTAKER McBoon ADDRESS Corvallis Ore