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CERTIFICATE OF DEATH

Vital Records Unit

Local File Number 84-219

State File Number 64

DECEDENT

1 DECEASED—NAME: First TRUMAN; Middle FOSTER; Last WING

2 DATE OF DEATH (month, day, year): February 18, 1983

3 RACE White, Black, American Indian, etc. (specify): White

4 SEX: Male

5a AGE—Last birthday (years): 81

5b Under 1 year: mos / days

5c Under 1 day: hours / min

6 DATE OF BIRTH (month, day, year): December 20, 1901

7a CITY, TOWN OR LOCATION OF DEATH: Klamath Falls

7b HOSPITAL OR OTHER INSTITUTION—NAME (If not in either, give street and number): Kl.Co.Nursing Home

7c IF HOSP. OR INST. Indicate DOA, OP/Emer. Rm., Inpatient [Specify]: Inpatient

7d COUNTY OF DEATH: Klamath

8 STATE OF BIRTH (If not in U.S.A., name country): Nebraska

9 CITIZEN OF WHAT COUNTRY: U.S.A.

10 MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

11 SPOUSE (IF MARRIED, WIDOWED): Margaret Wing

12 WAS DECEDENT EVER IN U.S. ARMED FORCES? [Specify Yes or No]: No

13 SOCIAL SECURITY NUMBER: 543-10-0155

14a USUAL OCCUPATION (give kind of work done during most of working life, even if retired): Conductor

14b KIND OF BUSINESS OR INDUSTRY: Weyerhauser Co.

15a RESIDENCE—STATE: Oregon

15b COUNTY: Klamath

15c CITY, TOWN, OR LOCATION: Klamath Falls

15d STREET AND NUMBER OR R.F.D., ZIP: 725 St. Francis

15e Inside City Limits (specify yes or no): Yes

16 FATHER—NAME first middle last: Frank Wing

17 MOTHER—Maiden Name first middle last: Anna Foster

18 INFORMANT—NAME and relationship to deceased: Margaret Wing - Wife

19a BURIAL, CREMATION, REMOVAL, MAUS. (specify): Mausoleum

19b CEMETERY OR CREMATORY—NAME: Eternal Hills Mem. Gardens

19c LOCATION city or town, state: Klamath Falls, Oregon

20a FUNERAL SERVICE LICENSEE Or Person Acting As Such [Signature]: [signature]

20b NAME AND ADDRESS OF FACILITY: Ward's - 1945 Main St. - Klamath Falls, Oregon

To be Completed by CERTIFYING PHYSICIAN Only

To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated

21a [Signature]: [signature]

21b DATE SIGNED [Mo., Day, Yr.]: 2/21/83

21c HOUR OF DEATH: 9:50 P.M

21d NAME AND ADDRESS OF CERTIFIER [Type or Print]: Thomas E. Klump, MD 2600 Clover Klamath Falls, Oregon

21e NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER [Type or Print]:

22a DATE RECEIVED BY REGISTRAR [Mo., Day, Yr.]: FEB 22 1983

22b REGISTRAR [Signature]: [signature]

CAUSE OF DEATH

PART I

23 IMMEDIATE CAUSE [ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c).]

(a) Probable Malignant Brain Tumor — Interval between onset and death: 2½ mos.

DUE TO, OR AS A CONSEQUENCE OF:

(b) — Interval between onset and death:

DUE TO, OR AS A CONSEQUENCE OF:

(c) — Interval between onset and death:

PART II OTHER SIGNIFICANT CONDITIONS—Conditions contributing to death but not related to cause given in PART I (a):

24 ACCIDENT [Specify Yes or No]: No

25 AUTOPSY [Specify Yes or No]: No

26a INJURY AT WORK [Specify Yes or No]: No

26b DATE OF INJURY [Mo., Day, Yr.]:

26c HOUR OF INJURY:

26d DESCRIBE HOW INJURY OCCURRED:

26e PLACE OF INJURY—At home, farm, street, factory, office building, etc. [Specify]:

26f LOCATION STREET OR R.F.D. NO. CITY OR TOWN STATE:

WAS MEDICAL EXAMINER NOTIFIED [Specify Yes or No]: No

RESERVED FOR REGISTRAR'S USE

STATE OF OREGON
County of Klamath

VS-2 (Rev 1/80)

This certifies that the foregoing is a correct and complete transcript of a record of death on file with the Klamath County Department of Health Services.

MARIAN ACKERMAN, Registrar Vital Statistics

By [signature], Deputy Registrar

Date MAR 2 1983

VOID IF ALTERED

(SEAL)

NOT VALID WITHOUT RAISED SEAL OF THE KLAMATH CO. DEPT OF HEALTH SERVICES

c lc 4.00

STATE OF OREGON: COUNTY OF KLAMATH :ss

I hereby certify that the within instrument was received and filed for record on the 9th day of March A.D., 19 83 at 2:29 o'clock P M, and duly recorded in Vol M83, of Deeds on page 3616

Fee $4.00

EVELYN BIEHN COUNTY CLERK

by [signature] Deputy