

48434

OREGON STATE HEALTH DIVISION  
DEPARTMENT OF HUMAN RESOURCES

Vol. M85 Page 6629

Vital Records Unit  
CERTIFICATE OF DEATH

169  
Local File Number

DECEASED—NAME First Middle Last  
Truman Owen BATES

DATE OF DEATH (month, day, year)  
2 April 28, 1985

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

SEX  
Male

AGE—Last birthday (years)  
5a 71

Under 1 year: mos. days hours min.  
Under 1 day

DATE OF BIRTH (month, day, year)  
6 April 9, 1914

CITY, TOWN OR LOCATION OF DEATH  
7a Chiloquin

HOSPITAL OR OTHER INSTITUTION—NAME (If not in either, give street and number)  
7b Rt. 1 Box 1700

IF HOSP. OR INST. Indicate DOA, Op/Emr., Rm., Inpatient (Specify)  
7c

COUNTY OF DEATH  
7d Klamath

STATE OF BIRTH (If not in U.S.A. name country)  
8 Kansas

CITIZEN OF WHAT COUNTRY  
9 U.S.A.

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

SPOUSE (IF MARRIED, WIDOWED)  
11 Betty

WAS DECEDENT EVER IN U.S. ARMED FORCES? (Specify Yes or No)  
12 No

SOCIAL SECURITY NUMBER  
13 514-05-2106

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

KIND OF BUSINESS OR INDUSTRY  
14b Pacific Gas

RESIDENCE—STATE  
15a Oregon

COUNTY  
15b Klamath

CITY, TOWN, OR LOCATION  
15c Chiloquin

STREET AND NUMBER OR R.F.D. NO.  
15d Rt. 1 Box 1700

Inside City Limits (Specify Yes or No)  
15e No

FATHER—NAME first middle last  
16 Harvey Albert Bates

MOTHER—first middle last (Maiden Name)  
17 Emma Olive Owen

INFORMANT—NAME and relationship to deceased  
18 Betty Bates - Wife

BURIAL, CREMATION, REMOVAL, MAUS. (specify)  
19a Cremation

CEMETERY OR CREMATORY—NAME  
19b Siskiyou Crematory

LOCATION city or town state  
19c Medford, Oregon

FUNERAL SERVICE LICENSEE Or Person Acting As Such (Signature)  
20a Jay Millard

NAME AND ADDRESS OF FACILITY  
20b Dayspring National Memorial Society, P.O. Box 4548, Medford

To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated:  
21a David D. Reeder M.D.

DATE SIGNED (Mo., Day, Yr.)  
21b 5-1-85

HOUR OF DEATH  
21c 1:00 A. M

NAME AND ADDRESS OF CERTIFIER (Type or Print)  
21d David Reeder, M.D., 2301 Mt. View Blvd, Klamath Falls, Oregon 97601

NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)  
21e

DATE RECEIVED BY REGISTRAR (Mo., Day, Yr.)  
22a MAY 1 1985

REGISTRAR  
22b [Signature]

23 IMMEDIATE CAUSE (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c).)  
PART I (a) MYOCARDIAL INFARCTION  
DUE TO, OR AS A CONSEQUENCE OF  
(b) Atherosclerosis  
DUE TO, OR AS A CONSEQUENCE OF  
(c) OTHER SIGNIFICANT CONDITIONS—Conditions contributing to death but not related to cause given in PART I (a)

Interval between onset and death  
MINUTES  
Interval between onset and death  
YEARS

AUTOPSY (Specify Yes or No)  
24 No

WAS MEDICAL EXAMINER NOTIFIED (Specify Yes or No)  
25 Yes

ACCIDENT (Specify Yes or No)  
26a No

DATE OF INJURY (Mo., Day, Yr.)  
26b

HOUR OF INJURY  
26c

DESCRIBE HOW INJURY OCCURRED  
26d

INJURY AT WORK (Specify Yes or No)  
26e No

PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify)  
26f

LOCATION  
26g

STREET OR R.F.D. NO.  
CITY OR TOWN  
STATE

RESERVED FOR REGISTRAR'S USE

ORIGINAL - VITAL STATISTICS COPY

45-2 HEV. 12-83

STATE OF OREGON

County of Klamath

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 MAY 3 1985

VOID IF ALTERED

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

Return Betty Bates, Rt. 1 Box 1700, Chiloquin, Or 9762-9714

STATE OF OREGON: COUNTY OF KLAMATH:ss

I hereby certify that the within instrument was received and filed for record on the 6th day of May A.D., 1985 at 2:04 o'clock P M, and duly recorded in Vol. M85, of Deeds on page 6629.

EVELYN BIEHN, COUNTY CLERK

by: [Signature], Deputy

Fee: \$ 5.00