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STATE OF OREGON
DEPARTMENT OF HUMAN RESOURCES
Vital Records Unit

CERTIFICATE OF DEATH

TYPE OR PRINT IN PERMANENT BLACK INK FOR INSTRUCTIONS SEE HANDBOOK

PRECEDENT

POSITION

CERTIFIER

CONDITIONS IF ANY WHICH GAVE RISE TO IMMEDIATE CAUSE

CAUSE OF DEATH

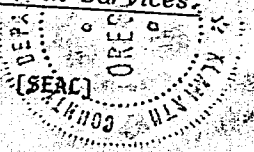
DECEASED—NAME First Middle Last JAMES ALBERT JACKSON		State File Number
1 RACE White, Black, American Indian, etc. (specify) White	2 SEX Male	3 DATE OF DEATH (month, day, year) June 28, 1985
4 CITY, TOWN OR LOCATION OF DEATH Klamath Falls	5a AGE—Last birthday (years) 64	5b Under 1 year Under 1 day
6a HOSPITAL OR OTHER INSTITUTION—NAME (If not in either, give street and number) Merle West Medical Center	6b IF HOSP. OR INST. Indicate DOA, OP, Emer., Am., Inpatient (Specify) Inpatient	7 DATE OF BIRTH (month, day, year) December 28, 1920
8 STATE OF BIRTH (If not in U.S.A., name country) Arkansas	9 CITIZEN OF WHAT COUNTRY U.S.A.	10 MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married
11 SOCIAL SECURITY NUMBER 431 - 26 - 6531	12 USUAL OCCUPATION (give kind of work done during most of working life, even if retired) Laborer - Retired	13 SPOUSE (IF MARRIED, WIDOWED) Vera
14a RESIDENCE—STATE Oregon	14b COUNTY Klamath	14c CITY, TOWN, OR LOCATION Klamath Falls
15a FATHER—NAME first middle last Alvin H. Jackson	15b MOTHER—first middle last Ella Brooks	15c STREET AND NUMBER OR R.F.D., ZIP Route 3 / Box 234 P
16 BURIAL, CREMATION, REMOVAL, MAUS. (specify) Burial	17 CEMETERY OR CREMATORY—NAME Eternal Hills Memorial Gardens	18 INFORMANT—NAME and relationship to deceased James Jackson / Son
19a FUNERAL SERVICE LICENSEE Or Person Acting As Such (Signature) James Jackson	19b NAME AND ADDRESS OF FACILITY WARD'S - 1945 Main - Klamath Falls, Ore. 97601	19c LOCATION city or town state Klamath Falls, Ore.
20a To be Completed by Certifying Physician Only 20b I, the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated 20c NAME AND ADDRESS OF CERTIFIER (Type or Print) Earle M. LeVernois, MD / 2628 Campus Dr / Klamath Falls, Ore. 97601	21a DATE RECEIVED BY REGISTRAR (Mo., Day, Yr.) JUL 2 1985	21b REGISTRAR Marian Ackerman
22a PART I IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF: (b) METASTATIC CARCINOMA DUE TO, OR AS A CONSEQUENCE OF: (c) PRIMARY CARCINOMA OF LEFT LUNG	22b INTERVAL BETWEEN ONSET AND DEATH Terminal Known 2 months Known 2 months	22c
23 PART II OTHER SIGNIFICANT CONDITIONS—Conditions contributing to death but not related to cause given in PART I (a) ACCIDENT (Specify Yes or No) NO	24 DATE OF INJURY (Mo., Day, Yr.) 26b	25 HOUR OF INJURY 26c
26a INJURY AT WORK (Specify Yes or No) NO	26b PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify) 26d	26c DESCRIBE HOW INJURY OCCURRED 26e
26d LOCATION 26e STREET OR R.F.D. NO. 26f CITY OR TOWN 26g STATE		

ORIGINAL - VITAL STATISTICS COPY

45-2 REV. 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 Marian Ackerman, Deputy RegistrarDate JUL 5 1985

VOID IF ALTERED

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

STATE OF OREGON: COUNTY OF KLAMATH:ss
I hereby certify that the within instrument was received and filed for record on the 2nd day of July A.D., 1985 at 1:37 o'clock P M, and duly recorded in Vol M85 of Deeds on page 10221.

Fee: \$ 5.00

EVELYN BIEHN, COUNTY CLERK
by: Pam Smith, Deputy