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STATE OF OREGON
OREGON STATE HEALTH DIVISION
DEPARTMENT OF HUMAN SERVICES
Vital Records Unit

CERTIFICATE OF DEATH

06264 ID TAG NO.
184 Local File Number
TYPE OR PRINT IN PERMANENT BLACK INK. FOR INSTRUCTIONS SEE HANDBOOK

DECEDENT

DECEASED — NAME: 1 First: Farris Middle: E. Last: FOSTER
State File Number
2 DATE OF DEATH (month, day, year): May 17, 1986
3 RACE White, Black, American Indian, etc. (specify): White
4 SEX: Male
5a AGE — Last birthday (years): 84
5b Under 1 year: mos. / days
5c Under 1 day: hours / min.
6 DATE OF BIRTH (month, day, year): September 6, 1901
7a CITY, TOWN OR LOCATION OF DEATH: Klamath Falls
7b HOSPITAL OR OTHER INSTITUTION — NAME (If not in either, give street and number): West Medical Center
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): Arkansas
9 CITIZEN OF WHAT COUNTRY: U.S.A.
10 MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
11 SPOUSE (IF MARRIED, WIDOWED): Bessie McGowen
12 WAS DECEDENT EVER IN U.S. ARMED FORCES? (specify yes or no): No
13 SOCIAL SECURITY NUMBER: 543-10-1237
14a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plannerman
14b KIND OF BUSINESS OR INDUSTRY: Weyerhaeuser Company
15a RESIDENCE — STATE: Oregon
15b COUNTY: Klamath
15c CITY, TOWN OR LOCATION: Klamath Falls
15d STREET AND NUMBER OR R.F.D.: 2926 Altamont Drive ZIP: 97603
15e Inside City Limits (specify yes or no): No
16 FATHER — NAME first middle last: Robert Jordan Foster
17 MOTHER — first middle last (Maiden Name): Susie — Hamm
18 INFORMANT — NAME and relationship to deceased: Bessie M. Foster, wife

DISPOSITION

19a BURIAL, CREMATION, REMOVAL, MAUS. (specify): Burial
19b CEMETERY OR CREMATORY — NAME: Eternal Hills Memorial Gardens
19c LOCATION city or town state: Klamath Falls, Oregon 976
20a FUNERAL SERVICE LICENSEE or person acting as such (Signature): William F. Davenport
20b NAME AND ADDRESS OF FACILITY: Davenport's Chapel of the Good Shepherd, 6420 South Sixth Street, Klamath Falls, Oregon 97603-7194

CERTIFIER

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): Alden B. Glidden MD
DATE SIGNED (Mo., Day, Year) 21b: May 19, 1986
HOUR OF DEATH 21c: 10:35 P.M
21d NAME, TITLE AND ADDRESS OF CERTIFIER (Type or Print): Alden B. Glidden, MD, 2680 Uhrmann Road, Klamath Falls, Oregon ZIP: 97601
21e NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)

22a DATE RECEIVED BY REGISTRAR (Mo., Day, Year): May 19, 1986
22b REGISTRAR (Signature): Katherine E. Cravens

CAUSE OF DEATH

CONDITIONS IF ANY WHICH GAVE RISE TO IMMEDIATE CAUSE STATING THE UNDERLYING CAUSE LAST

23 IMMEDIATE CAUSE (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b) AND (c).)
PART I (a) DUE TO, OR AS A CONSEQUENCE OF: Acute pulmonary edema — Interval between onset and death: Acute
(b) DUE TO, OR AS A CONSEQUENCE OF: Chronic congestive heart failure — Interval between onset and death: 1½ years
(c) DUE TO, OR AS A CONSEQUENCE OF: Subacute Bacterial Endocarditis — Interval between onset and death: 1½ years
PART II OTHER SIGNIFICANT CONDITIONS — Conditions contributing to death but not related to cause given in PART I (a): Carcinoma of the Prostate
AUTOPSY (Specify Yes or No) 24: No
WAS MEDICAL EXAMINER NOTIFIED (Specify Yes or No) 25: No

ACCIDENT (Specify Yes or No) 26a: No
26b DATE OF INJURY (Mo., Day, Year)
26c HOUR OF INJURY
26d DESCRIBE HOW INJURY occurred
INJURY AT WORK (Specify Yes or No) 26e: No
26f PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
26g LOCATION STREET OR R.F.D. NO. CITY OR TOWN STATE

DID HOSPITAL REPRESENTATIVE MAKE REQUEST FOR ANATOMICAL GIFT CONSENT? YES ☐ NO ☐ N/A ☐
WAS GIFT MADE? YES ☐ NO ☐ N/A ☐
RESERVED FOR REGISTRAR'S USE

ORIGINAL–VITAL STATISTICS COPY

45-2 Rev. 1-86

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.

SEAL

MARIAN ACKERMAN, Registrar Vital Statistics
By Katherine E. Cravens Deputy Regisrtar
Date May 19, 1986
VOID IF ALTERED

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

STATE OF OREGON: COUNTY OF KLAMATH: ss.

Filed for record at request of _____ of May A.D., 19 86 at 12:03 o'clock P M., and duly recorded in Vol. M86 of Deeds on Page 8642 the 20th day

FEE $5.00

Evelyn Biehn, County Clerk
By _____