68605 '86 NOV 24 PM 12 54

A 0563
ID TAG NO.

515
Local File Number

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

Vol M86 Page 21645

CERTIFICATE OF DEATH

TYPE OR PRINT IN PERMANENT BLACK INK — FOR INSTRUCTIONS SEE HANDBOOK

DECEDENT — IF DEATH OCCURRED IN INSTITUTION, SEE HANDBOOK REGARDING COMPLETION OF RESIDENCE ITEMS

1 DECEASED — NAME: First: Henry; Middle: Carl; Last: RIVERS; State File Number:
2 DATE OF DEATH (month, day, year): November 20, 1986
3 RACE White, Black, American Indian, etc. (specify): White
4 SEX: Male
5a AGE — Last birthday (years): 48
5b Under 1 year: mos. / days
5c Under 1 day: hours / min.
6 DATE OF BIRTH (month, day, year): June 19, 1938
7a CITY, TOWN OR LOCATION OF DEATH: Bend
7b HOSPITAL OR OTHER INSTITUTION — NAME (If not in either, give street and number): St. Chas. Med. Cent.
7c IF HOSP. OR INST. Indicate DOA, OP/Emer. Rm., Inpatient (specify): Inpatient
7d COUNTY OF DEATH: Deschutes
8 STATE OF BIRTH (If not in U.S.A., name country): Oregon
9 CITIZEN OF WHAT COUNTRY: U.S.A.
10 MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
11 SPOUSE (IF MARRIED, WIDOWED): Beverly
12 WAS DECEDENT EVER IN U.S. ARMED FORCES? (specify yes or no): Yes
13 SOCIAL SECURITY NUMBER: 544-42-9161
14a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Driver
14b KIND OF BUSINESS OR INDUSTRY: Trucking
15a RESIDENCE — STATE: Oregon
15b COUNTY: Klamath
15c CITY, TOWN OR LOCATION: Gilchrist
15d STREET AND NUMBER OR R.F.D.: P.O. Box 350
ZIP: 97737
15e Inside City Limits (specify yes or no): No
16 FATHER — NAME first middle last: Henry F. Rivers
17 MOTHER — first middle last (Maiden Name): Ruth Amen
18 INFORMANT — NAME and relationship to deceased: Beverly K. Rivers - Wife

DISPOSITION

19a BURIAL, CREMATION, REMOVAL, MAUS. (specify): Cremation
19b CEMETERY OR CREMATORY — NAME: Central Oregon Cremation Asso.
19c LOCATION — city or town, state: Bend, Oregon
20a FUNERAL SERVICE LICENSEE or person acting as such (Signature): [signature]
20b NAME AND ADDRESS OF FACILITY: TABOR'S Desert Hills MORTUARY 1441 N.E. FORBES RD. BEND, OR 97701

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): [signature] MD
21b DATE SIGNED (Mo., Day, Year): 11-20-86
21c HOUR OF DEATH: 5:05 A. M
21d NAME, TITLE AND ADDRESS OF CERTIFIER (Type or Print): Daniel E. Fohrman, M.D. 1501 N.E. Medical Center Dr. Bend, Or. ZIP 97701
21e NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print):

22a DATE RECEIVED BY REGISTRAR (Mo., Day, Year): November 20, 1986
22b REGISTRAR (Signature): Jacqueline Mathis, Dep.

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) C.A. LUNG — Interval between onset and death: 4-8 WEEKS
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).

ACCIDENT (Specify Yes or No)	DATE OF INJURY (Mo., Day, Year)	HOUR OF INJURY	DESCRIBE HOW INJURY OCCURRED	AUTOPSY (Specify Yes or No)	WAS MEDICAL EXAMINER NOTIFIED (Specify Yes or No)
26a No	26b	26c M	26d	24 No	25 No

INJURY AT WORK (Specify Yes or No)	PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	LOCATION — STREET OR R.F.D. NO.	CITY OR TOWN	STATE
26e	26f	26g		

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 6-86

STATE OF OREGON, COUNTY OF DESCHUTES

I HEREBY CERTIFY THAT THE FOREGOING COPY HAS BEEN COMPARED BY ME WITH THE ORIGINAL DOCUMENT AND IS A TRUE, FULL AND CORRECT COPY OF THE ORIGINAL CERTIFICATE AS THE SAME APPEARS ON FILE IN THE VITAL RECORDS UNIT OF THE DESCHUTES COUNTY HEALTH DEPARTMENT AND IN MY OFFICIAL CARE AND CUSTODY.

NOT VALID WITHOUT RAISED SEAL OF DESCHUTES COUNTY HEALTH DEPARTMENT

Jacqueline Mathis, Deputy Registrar
JACQUELINE MATHIS, DEPUTY REGISTRAR

November 20, 1986
DATE

Ret/ Beverly Rivers
BK 5.00 P.O. Box 350
Gilchrist, Oregon 97737

STATE OF OREGON: COUNTY OF KLAMATH: ss.

Filed for record at request of _____
of November A.D., 19 86 at 12:54 o'clock P M., and duly recorded in Vol. M86, the 24th day of Deeds on Page 21645.

FEE $5.00

Evelyn Biehn, County Clerk
By _____