

TYPE
CREAM
OR
PERMANENT
BLACK
INK
FOR
INSTRUCTIONS
SEE
HANDBOOK

DECEDENT

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

DISPOSITION

1
2
3

CERTIFIER

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

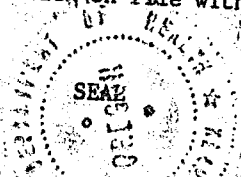
CAUSE OF DEATH

4
5
6

\$5.00
Cash

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 Registrar

Date March 31, 1987

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 Lindley Fogel
of March A.D., 19 87 at 4:01 o'clock P M., and duly recorded in Vol. M87
of Deeds on Page 5333.

FEE \$5.00

Return: Lindley Fogel

Evelyn Biehn, County Clerk

By Marian Ackerman
4742 Shasta Way, Klamath Falls, Oregon 97603

OREGON STATE HEALTH DIVISION
DEPARTMENT OF HUMAN SERVICES
Vital Records Unit

CERTIFICATE OF DEATH

DECEASED - NAME First Middle Last LOLA MYRTLE FOGEL		State File Number	
RACE White, Black, American Indian, etc. (specify) White		DATE OF DEATH (month, day, year) 2 March 28, 1987	
AGE - Last birthday (years) 75		DATE OF BIRTH (month, day, year) 6 July 4, 1911	
CITY, TOWN OR LOCATION OF DEATH Klamath Falls		COUNTY OF DEATH Klamath	
HOSPITAL OR OTHER INSTITUTION - NAME (If not in either, give street and number) Merle West Medical Center		IF HOSP. OR INST. indicate DOA, OP/Emr. Rm., Inpatient (specify) Inpatient	
CITIZEN OF WHAT COUNTRY U.S.A.		SPOUSE (IF MARRIED, WIDOWED) Lindley	
MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married		WAS DECEDENT EVER IN U.S. ARMED FORCES? (specify yes or no) NO	
SOCIAL SECURITY NUMBER 540-20-4887		KIND OF BUSINESS OR INDUSTRY	
USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		KIND OF BUSINESS OR INDUSTRY At Home	
RESIDENCE - STATE Oregon		CITY, TOWN OR LOCATION Klamath Falls	
FATHER - NAME first middle last Fred Smith		MOTHER - first middle last Sarah Varner	
BURYAL, CREMATION, REMOVAL, MAUS. (specify) Cremation		CEMETERY OR CREMATORY - NAME Eternal Hills Memorial Gardens	
FUNDUS SERVICE LICENSEE or person acting as such (Signature) <u>Jim Lancaster</u>		NAME AND ADDRESS OF FACILITY Ward's Funeral Home / 1945 Main St. / Klamath Falls, Ore.	
To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated. 21a (Signature) <u>Glenn Gailis MD</u>		DATE SIGNED (Mo., Day, Year) 3/30/87	
NAME, TITLE AND ADDRESS OF CERTIFIER (Type or Print) Glenn Gailis, MD - 1905 Main St. - Klamath Falls, Oregon		HOUR OF DEATH 6:18 A.M.	
NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)		ZIP 97601	
DATE RECEIVED BY REGISTRAR (Mo., Day, Year) MAR 30 1987		REGISTRAR <u>Marian Ackerman</u>	
PART I IMMEDIATE CAUSE (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b) AND (c).)			
(a) PNEUMONIA		Interval between onset and death 1 WEEK	
(b) EMPHYSEMA AND ASTHMA		Interval between onset and death YEARS	
(c) CONGESTIVE HEART FAILURE		Interval between onset and death YEARS	
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		DATE OF INJURY (Mo., Day, Year)	
HOUR OF INJURY		DESCRIBE HOW INJURY OCCURRED	
INJURY AT WORK (Specify Yes or No) NO		PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)	
LOCATION		STREET OR R.F.D. NO.	
CITY OR TOWN		STATE	
DID HOSPITAL REPRESENTATIVE MAKE REQUEST FOR ANATOMICAL GIFT CONSENT? YES <input type="checkbox"/> NO <input type="checkbox"/> N/A <input type="checkbox"/>			
WAS GIFT MADE? YES <input type="checkbox"/> NO <input type="checkbox"/> N/A <input type="checkbox"/>			
RESERVED FOR REGISTRAR'S USE			

ORIGINAL-VITAL STATISTICS COPY

46-2 Rev. 6-81