

CERTIFICATION OF VITAL RECORD

D-5536
I.D. TAG NO.OREGON DEPARTMENT OF HUMAN RESOURCES
HEALTH DIVISION
Vital Records Unit
CERTIFICATE OF DEATH

136-

State File Number

1. DECEDENT'S NAME First: Thomas Middle: Oran Last: DYCHE		2. SEX M	3. DATE OF DEATH (Month, Day, Year) March 2, 1989
4. SOCIAL SECURITY NUMBER 518-16-8660	5a. AGE - Last Birthday (Years) 86	5b. Under 1 Year Mos. Days Hours Mins.	6. BIRTHPLACE (City and State or Foreign Country) Dayton, Washington
7. DATE OF BIRTH (Month, Day, Year) July 9, 1902			
8. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Decedent's Home <input type="checkbox"/> Other (Specify):			
9a. FACILITY NAME (If not institution, give street and number) 2326 Eberlein		9b. CITY, TOWN, OR LOCATION OF DEATH Klamath Falls	
9c. COUNTY OF DEATH Klamath		10. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Cat Skinner	
10a. DECEDENT'S USUAL OCCUPATION Cat Skinner		10b. KIND OF BUSINESS/INDUSTRY Logging	
11. MARITAL STATUS - Married, Never Married, Widowed, Divorced (Specify) Married		12. SPOUSE (If Married, Widowed) Jessie May	
13a. RESIDENCE - STATE Oregon		13b. COUNTY Klamath	
13c. CITY, TOWN, OR LOCATION Klamath Falls		13d. STREET AND NUMBER 2326 Eberlein	
14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Specify:		15. RACE American Indian, Black, White, etc. (Specify) White	
16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (14 or 5+) 3		17. INFORMANT - NAME and relationship to decedent Jessie May Dyche, wife	
18. FATHER - NAME first middle last Thomas James Dyche		19. MOTHER - NAME first middle maiden Carlotta - Springer	
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify):		20b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) Eternal Hills Crematory	
21a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH William F. Davenport		21b. LICENSE NUMBER (Of Licensee) 47-3104	
22. NAME, ADDRESS AND ZIP OF FACILITY of the Good Shepherd, 6420 So. 6th St., Klamath Falls, Oregon 97603-7194		23. DATE FILED (Month, Day, Year) MAR 3 1989	
24. REGISTRAR'S SIGNATURE Nancy Kennedy		25. DID HOSPITAL REPRESENTATIVE MAKE REQUEST FOR ANATOMICAL GIFT CONSENT? <input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> N/A	
TO BE COMPLETED BY CERTIFYING PHYSICIAN			
27. TIME OF DEATH 0628 A M		28. WAS MEDICAL EXAMINER NOTIFIED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
29. To the best of my knowledge, death occurred at the time, date, place and due to the cause(s) and manner stated. (Signature) Jon S. Wayland MD			
30. DATE SIGNED (Month, Day, Year) March 2, 1989			
31. NAME, TITLE, ADDRESS AND ZIP OF CERTIFYING MEDICAL EXAMINER (Type or Print) Jon S. Wayland, MD, 2301 Mountain View Blvd., Klamath Falls, Oregon 97601			
32. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print) Jon S. Wayland			
33. IMMEDIATE CAUSE (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c). Do not enter mode of dying, e.g. Cardiac or Respiratory Arrest.)			
PART I (a) DUE TO, OR AS A CONSEQUENCE OF: Circulation of coronary		Interval between onset and death	
(b) DUE TO, OR AS A CONSEQUENCE OF:		Interval between onset and death	
(c) OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not related to cause given in PART I.		Interval between onset and death	
34. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Undetermined Manner <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Legal Intervention		35. Did tobacco use contribute to the death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
36. DATE OF INJURY (Month, Day, Year)		37. TIME OF INJURY M	
38. INJURY AT WORK? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		39. AUTOPSY <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
40. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)		41. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
42. DESCRIBE HOW INJURY OCCURRED			
RESERVED FOR REGISTRAR'S USE			

ORIGINAL - VITAL STATISTICS COPY

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DATE ISSUED MAR 6 1989

Marian Ackerman
COUNTY REGISTRAR
KLAMATH COUNTY, OREGON

STATE OF OREGON: COUNTY OF KLAMATH: ss.

Filed for record at request of Jessie M. Dyche the 8th day of March A.D., 19 89 at 9:49 o'clock A.M., and duly recorded in Vol. M89 of Deeds on Page 3929.

Evelyn Biehn County Clerk
By Laurie Morrison

FEE \$8.00

Return: Jessie M. Dyche
2326 Eberlein, Klamath Falls, Or. 97601