

CERTIFICATION OF VITAL RECORD

OREGON DEPARTMENT OF HUMAN RESOURCES

HEALTH DIVISION

Vital Records Unit

CERTIFICATE OF DEATH

1. DECEDENT'S NAME First: Carrie K. Last: CAMPBELL		2. SEX F	3. DATE OF DEATH (Month, Day, Year) February 13, 1989
4. SOCIAL SECURITY NUMBER 544-84-7831		5a. AGE - Last Birthday (1/24) 75	5b. Under 1 Year Mos. Days Hours Mins.
6. BIRTHPLACE (City and State or Foreign Country) Tuber, Texas		7. DATE OF BIRTH (Month, Day, Year) July 10, 1913	
8. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
9a. PLACE OF DEATH (Check only one) <input type="checkbox"/> Hospital <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> Other: Nursing Home <input type="checkbox"/> Decedent's Home <input type="checkbox"/> Other (Specify)			
9b. FACILITY NAME (If not institution, give street and number) West Care Home		9c. CITY, TOWN, OR LOCATION OF DEATH Klamath Falls	
10a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Homemaker		10b. KIND OF BUSINESS/INDUSTRY Own Home	
11. MARITAL STATUS - Married, Never Married, Widowed, Divorced (Specify) Married		12. SPOUSE (If Married, Widowed) Irwin E.	
13a. RESIDENCE - STATE Oregon		13b. COUNTY Klamath	
13c. CITY, TOWN, OR LOCATION Klamath Falls		13d. STREET AND NUMBER 7313 Flag Court	
13e. INSIDE CITY LIMITS? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		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	
15. RACE American Indian, Black, White, etc. (Specify) White		16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12)	
17. FATHER - NAME first middle last Charles - Kucera		18. MOTHER - NAME first middle maiden Mary	
19. INFORMANT - NAME and relationship to deceased Irwin E. Campbell, husband		20c. LOCATION - City or Town, State Klamath Falls, Oregon	
20a. METHOD OF DISPOSITION <input type="checkbox"/> Mausoleum <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Mt. Calvary Cemetery		20b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) Mt. Calvary Cemetery	
21a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH Merrill Beil		21b. LICENSE NUMBER (Of Licensee) 3329	
22. NAME, ADDRESS AND ZIP OF FACILITY O'Hair's Funeral Chapel 97601 515 Pine St., Klamath Falls, Ore.		23. DATE FILED (Month, Day, Year) FEB 14 1989	
24. REGISTRAR'S SIGNATURE Nancy Kennedy		25. DID HOSPITAL REPRESENTATIVE MAKE REQUEST FOR ANATOMICAL GIFT CONSENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> N/A	
26. WAS GIFT MADE? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> N/A		27. TIME OF DEATH 2:25 P. M. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28. TO THE BEST OF MY KNOWLEDGE, DEATH OCCURRED AT THE TIME, DATE, PLACE AND DUE TO THE CAUSE(S) AND MANNER STATED. (Signature) Kenneth K. Magee M.D.		29. DATE SIGNED (Month, Day, Year) February 14, 1989	
30. NAME, TITLE, ADDRESS AND ZIP OF CERTIFIER/MEDICAL EXAMINER (Type or Print) Kenneth K. Magee, M.D., 1900 Main Street, Klamath Falls, Oregon 97601		31. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)	
32. 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.) (a) <u>Ischemic</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>Recurrent Urinary Tract Infection & possible pulmonary infection</u> DUE TO, OR AS A CONSEQUENCE OF: (c) <u>Depressed Immune System</u> OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not related to cause given in PART I. <u>Longstanding Spherocytic Hemolytic Anemia -</u>		33. INTERVAL BETWEEN ONSET AND DEATH <u>2-3 days</u> <u>2-3 days</u> <u>4 days</u>	
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. DATE OF INJURY (Month, Day, Year)	
36. TIME OF INJURY M <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		37. INJURY AT WORK? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
38. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)		39. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
RESERVED FOR REGISTRAR'S USE			

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45-2 REV. 1-89

DATE ISSUED FEB 15 1989

Marian Ackerman
MARIAN ACKERMAN
COUNTY REGISTRAR
KLAMATH COUNTY, OREGON

STATE OF OREGON: COUNTY OF KLAMATH: ss.

Filed for record at request of Wm. M. Ganong
of March A.D., 19 89 at 4:03 o'clock P.M., and duly recorded in Vol. M89
of Deeds on Page 4316

FEE \$8.00

Return: Wm.M.Ganong
292 Main, Klamath Falls, Or. 97601

Evelyn Biehn, County Clerk

By D. Aulene Muckelbauer