

CERTIFICATION OF VITAL RECORD

D-7278		OREGON DEPARTMENT OF HUMAN RESOURCES		136-	
I.D. NO.		HEALTH DIVISION		State File Number	
15-89		Vital Records Unit			
Local File Number		CERTIFICATE OF DEATH			
1. DECEDENT'S NAME First Middle Last Ella Ailene HALL		2. SEX F		3. DATE OF DEATH (Month, Day, Year) January 6, 1989	
4. SOCIAL SECURITY NUMBER 541-30-5047		5a. AGE - Last Birthday 80		6. BIRTHPLACE (City and State or Foreign Country) Williams, Oregon	
7. DATE OF BIRTH (Month, Day, Year) October 16, 1908		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 checked="" type="checkbox"/> Hospital <input type="checkbox"/> Inpatient <input type="checkbox"/> EPOutpatient <input type="checkbox"/> DDA <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Decedent's Home <input type="checkbox"/> Other (Specify):	
9b. FACILITY NAME (If not institution, give street and number) Laurel Hill Nursing Center		9c. CITY, TOWN, OR LOCATION OF DEATH Grants Pass		9d. COUNTY OF DEATH Josephine	
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) Widowed	
12. SPOUSE (If Married, Widowed) Woodrow W.		13a. RESIDENCE - STATE Oregon		13b. COUNTY Klamath	
13c. CITY, TOWN, OR LOCATION Midland		13d. STREET AND NUMBER 10751 First		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 (1-4 or 5+) 12		17. FATHER - NAME first middle last Jasper Newton Larimore	
18. MOTHER - NAME first middle maiden Verda Mable Gibson		19. INFORMANT - NAME and relationship to deceased Rod Robinson - Son		20a. METHOD OF DISPOSITION <input type="checkbox"/> Mausoleum <input checked="" type="checkbox"/> Burial <input checked="" 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) Hull & Hull Crematory		20c. LOCATION - City or Town, State Grants Pass, Oregon		21a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH Diane J. Huel	
21b. LICENSE NUMBER (Of Licensee) 0041		22. NAME, ADDRESS AND ZIP OF FACILITY Hull & Hull Funeral Directors 612 NW "A" St., Grants Pass, OR 97526		23. DATE FILED (Month, Day, Year) January 10, 1989	
24. REGISTRAR'S SIGNATURE Lester J. Young		25. WAS GIFT MADE? <input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> N/A		26. HOSPITAL REPRESENTATIVE MAKE REQUEST FOR ANATOMICAL GIFT CONSENT? <input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> N/A	
27. TIME OF DEATH 7:50 A. M. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		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) Daniel L. Moline M.D.	
30. DATE SIGNED (Month, Day, Year) January 6, 1989		31. NAME, TITLE, ADDRESS AND ZIP OF CERTIFIER/MEDICAL EXAMINER (Type or Print) Daniel L. Moline, M. D., 124 Northwest Midland Ave., Grants Pass, OR 97526		32. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)	
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) Chronic Lymphocytic Leukemia DUE TO, OR AS A CONSEQUENCE OF: (b) DUE TO, OR AS A CONSEQUENCE OF: (c) OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not related to cause given in PART I: Diverticulosis; chronic gastric intestinal bleeding		34. Did tobacco use contribute to the death? <input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unk		35. AUTOPSY <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
36. 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		37. DATE OF INJURY (Month, Day, Year)		38. TIME OF INJURY M <input type="checkbox"/> Yes <input type="checkbox"/> No	
39. PLACE OF INJURY - At home, farm, street, factory, office, building, etc. (Specify)		40. LOCATION (Street and Number or Rural Route Number, City or Town, State)		41. DESCRIBE HOW INJURY OCCURRED	

ORIGINAL - VITAL STATISTICS COPY

45-2 REV. 1-89

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DATE ISSUED March 20, 1989

Lester J. Young

LA VERLA J. YOUNG
COUNTY REGISTRAR
JOSEPHINE COUNTY, OREGON

STATE OF OREGON: COUNTY OF KLAMATH: ss.

Filed for record at request of Rod Robinson the 21st day of March A.D., 19 89 at 12:31 o'clock P.M., and duly recorded in Vol. M89 of Deeds on Page 4724.

FEE \$8.00

Return: Rod Robinson
1492 Raydean Dr., Grants Pass, Or. 97527Evelyn Biehn County Clerk
By Dianne M. Moline