

CERTIFICATION OF VITAL RECORD

C-4621
I.D. TAG NO.

134

OREGON DEPARTMENT OF HUMAN RESOURCES
HEALTH DIVISION
Vital Records Unit
CERTIFICATE OF DEATH

136-

State File Number

1. DECEDENT'S NAME First: Sidney Middle: Arden Last: ALLEN			2. SEX M	3. DATE OF DEATH (Month, Day, Year) March 20, 1989
4. SOCIAL SECURITY NUMBER 5a. AGE - Last Birthday (Years) 68 5b. Under 1 Year Mos. Days Hours Mins. 5c. Under 1 Day			6. BIRTHPLACE (City and State or Foreign Country) Chicago, IL.	7. DATE OF BIRTH (Month, Day, Year) August 1, 1920
8. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
9a. PLACE OF DEATH (Check only one) <input checked="" type="checkbox"/> HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Decedent's Home <input type="checkbox"/> Other (Specify)				
9b. CITY, TOWN, OR LOCATION OF DEATH Klamath Falls			9c. COUNTY OF DEATH Klamath	
9d. FACILITY NAME (If not institution, give street and number) Merle West Medical Center			11. MARITAL STATUS - Married, Never Married, Widowed, Divorced (Specify) Married	
10a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) Vice-President			12. SPOUSE (If Married, Widowed) Bobbie	
10b. KIND OF BUSINESS/INDUSTRY Moving & Storage Co.			13d. STREET AND NUMBER 1621 Johnson Avenue	
13a. RESIDENCE - STATE Oregon			13b. CITY, TOWN, OR LOCATION Klamath Falls	
13c. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> Yes <input 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	
13d. ZIP CODE 97601			15. RACE American Indian, Black, White, etc. (Specify) White	
17. FATHER - NAME first middle last Myron Earl Allen			18. MOTHER - NAME first middle maiden Florence Harriett Zabel	
20a. METHOD OF DISPOSITION <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) Eternal Hills Memorial Gardens	
21a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH <i>[Signature]</i>			21b. LICENSE NUMBER (Of Licensee) 3409	
22. NAME, ADDRESS AND ZIP OF FACILITY Ward's Klamath Funeral Home 1945 Main Street Klamath Falls, Ore. / 97601			24. REGISTRAR'S SIGNATURE <i>Nancy Kennedy</i>	
23. DATE FILED (Month, Day, Year) MAR 21 1989			26. WAS GIFT MADE? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	
25. DID HOSPITAL REPRESENTATIVE MAKE REQUEST FOR ANATOMICAL GIFT CONSENT? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A				
TO BE COMPLETED BY CERTIFYING PHYSICIAN				
27. TIME OF DEATH 1830				
29. To the best of my knowledge, death occurred at the time, date, place and due to the cause(s) and manner stated. (Signature) <i>Robert T. Brouillard, MD</i>				
30. DATE SIGNED (Month, Day, Year) 3/21/89				
34. NAME, TITLE, ADDRESS AND ZIP OF CERTIFIER/MEDICAL EXAMINER (Type or Print) Robert T. Brouillard, MD / 2865 Daggett / Klamath Falls, Oregon / 97601				
35. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)				
TO BE COMPLETED ONLY BY MEDICAL EXAMINER				
31a. TIME OF DEATH M				
31b. DATE PRONOUNCED DEAD (Month, Day, Year, Hour) M				
32. On the basis of examination and/or investigation, in my opinion death occurred at the time, date, place and due to the cause(s) and manner stated. (Signature)				
33. DATE SIGNED (Month, Day, Year) COUNTY				
36. 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) Cause of the esophagus and 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.				
37. Did tobacco use contribute to the death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unk				
38. AUTOPSY <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
39. If YES were findings considered in determining cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A				
40. 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"/> Legal Intervention <input type="checkbox"/> Homicide				
41a. DATE OF INJURY (Month, Day, Year)				
41b. TIME OF INJURY M				
41c. INJURY AT WORK? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
41d. DESCRIBE HOW INJURY OCCURRED				
41e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)				
41f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				

ORIGINAL - VITAL STATISTICS COPY

THIS IS A TRUE AND EXACT REPRODUCTION OF THE DOCUMENT OFFICIALLY REGISTERED AT THE OFFICE OF THE KLAMATH COUNTY REGISTRAR.

DATE ISSUED
MAR 29 1989Marian Ackerman
COUNTY REGISTRAR
KLAMATH COUNTY, OREGON

STATE OF OREGON: COUNTY OF KLAMATH: ss.

Filed for record at request of Bobbie Allen the 30th day
of March A.D., 19 89 at 11:12 o'clock A.M., and duly recorded in Vol. M89
of Deeds on Page 5317
By Evelyn Biehn County Clerk

FEE \$8.00

Return: Bobbie Allen
1621 Johnson, Klamath Falls, Or. 97601