

## CERTIFICATION OF VITAL RECORD

I.D. TAG NO.

50

HEALTH DIVISION  
Vital Records Unit  
CERTIFICATE OF DEATH

136

State File Number

1. DECEDENT'S NAME First: Harvey Middle: C Last: BORGMAN		2. SEX M	3. DATE OF DEATH (Month, Day, Year) January 30, 1989
4. SOCIAL SECURITY NUMBER 552-03-6027		5a. AGE - Last Birthday (Years) 90	5b. Under 1 Year Mos. Days Hours Mins.
6. BIRTHPLACE (City and State or Foreign Country) Butte, Montana		7. DATE OF BIRTH (Month, Day, Year) October 26, 1898	
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 type="checkbox"/> Hospital <input checked="" type="checkbox"/> Inpatient <input checked="" 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. FACILITY NAME (If not institution, give street and number) Merle West Medical Center		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.) Merchandise Manager		10b. KIND OF BUSINESS/INDUSTRY Retail Drug Store	
11. MARITAL STATUS - Married, Never Married, Widowed, Divorced (Specify) Married		12. SPOUSE (If Married, Widowed) Isabelle	
13a. RESIDENCE - STATE Oregon		13b. COUNTY Klamath	
13c. CITY, TOWN, OR LOCATION Klamath Falls		13d. STREET AND NUMBER 863 Lakeshore Drive	
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 (0-12) College (14 or 5+) 2			
17. FATHER - NAME first middle last Henry A. Borgman		18. MOTHER - NAME first middle maiden Anna - Hanson	
19. INFORMANT - NAME and relationship to deceased Isabelle Borgman, wife			
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) Klamath Cremation Service		20b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) Klamath Falls, Oregon	
21a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH Merrill Reid		21b. LICENSE NUMBER (or 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 1 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 4:21 P. M.		28. WAS MEDICAL EXAMINER NOTIFIED? <input checked="" type="checkbox"/> Yes <input 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) F. Geoffrey Marx, M.D.		30. DATE SIGNED (Month, Day, Year) January 31, 1989	
31. NAME, TITLE, ADDRESS AND ZIP OF CERTIFIER/MEDICAL EXAMINER (Type or Print) F. Geoffrey Marx, M.D., 2614 Clover Street, Klamath Falls, Oregon 97601		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	
34. 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) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF: (b) Atherosclerosis DUE TO, OR AS A CONSEQUENCE OF: (c) OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not related to cause given in PART I.		Interval between onset and death 20 min. Interval between onset and death 30 yrs Interval between onset and death	
35. 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		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. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)		40. DESCRIBE HOW INJURY OCCURRED	
41. LOCATION (Street and Number or Rural Route Number, City or Town, State)			

ORIGINAL - VITAL STATISTICS COPY

45-2 REV. 1-89

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DATE ISSUED FEB 1 1989

Marian Ackerman  
MARIAN ACKERMAN  
COUNTY REGISTRAR  
KLAMATH COUNTY, OREGON

STATE OF OREGON: COUNTY OF KLAMATH: ss.

Filed for record at request of Wm. Ganong  
of April A.D., 19 89 at 4:31 o'clock P.M., and duly recorded in Vol. M89  
of Deeds on Page 6005

FEE \$8.00

Return: Wm. Ganong

P.O. Box 57, Klamath Falls, Or. 97601

Evelyn Biehn, County Clerk

By Pauline M. Mendenhall