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CERTIFICATION OF VITAL RECORD

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

53933 I.D. TAG NO.
180 Local File Number
136- State File Number

DECEDENT

1. DECEDENT'S NAME: First Floyd — Middle — Last EWING
2. SEX: M
3. DATE OF DEATH (Month, Day, Year): April 10, 1989
4. SOCIAL SECURITY NUMBER: 543-10-4743
5a. AGE - Last Birthday (Years): 70
5b. Under 1 Year: Mos. / Days
5c. Under 1 Day: Hours / Mins.
6. BIRTHPLACE (City and State or Foreign Country): Cliffton, Colorado
7. DATE OF BIRTH (Month, Day, Year): September 9, 1918
8. WAS DECEDENT EVER IN U.S. ARMED FORCES? X Yes ☐ No
9a. PLACE OF DEATH (Check only one): HOSPITAL: X Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Decedent's Home ☐ 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
9d. COUNTY OF DEATH: Klamath
10a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.): Cemetery Caretaker
10b. KIND OF BUSINESS/INDUSTRY: Cemetery
11. MARITAL STATUS - Married, Never Married, Widowed, Divorced (Specify): Married
12. SPOUSE (If Married, Widowed): Dorothy L.
13a. RESIDENCE - STATE: Oregon
13b. COUNTY: Klamath
13c. CITY, TOWN, OR LOCATION: Klamath Falls
13d. STREET AND NUMBER: 5304 Alva Street
13e. INSIDE CITY LIMITS? ☐ Yes X No
13f. ZIP CODE: 97603
14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.) X No ☐ Yes Specify:
15. RACE American Indian, Black, White, etc. (Specify): White
16. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):

PARENTS

17. FATHER - NAME first middle last: Lewis - Ewing
18. MOTHER - NAME first middle maiden: Etta - Douglas
19. INFORMANT - NAME and relationship to deceased: Dorothy L. Ewing, wife

DISPOSITION

20a. METHOD OF DISPOSITION: ☐ Mausoleum X Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): Mt. Calvary Cemetery
20c. LOCATION - City or Town, State: Klamath Falls, Oregon

21a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH: Merrill Reid
21b. LICENSE NUMBER (Of Licensee): 3329
22. NAME, ADDRESS AND ZIP OF FACILITY: O'Hair's Funeral Chapel, Inc. 515 Pine St., Klamath Falls, Ore. 97601

REGISTRAR

23. DATE FILED (Month, Day, Year): APR 12 1989
24. REGISTRAR'S SIGNATURE: Nancy Kennedy
25. DID HOSPITAL REPRESENTATIVE MAKE REQUEST FOR ANATOMICAL GIFT CONSENT? ☐ YES X NO ☐ N/A
26. WAS GIFT MADE? ☐ YES X NO ☐ N/A

CERTIFIER

TO BE COMPLETED BY CERTIFYING PHYSICIAN

27. TIME OF DEATH: 4:40 P. M
28. WAS MEDICAL EXAMINER NOTIFIED? ☐ Yes X 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): April 11, 1989

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

34. NAME, TITLE, ADDRESS AND ZIP OF CERTIFIER/MEDICAL EXAMINER (Type or Print): F. Geoffrey Marx, M.D., 2614 Clover Street, Klamatlh Falls, Oregon 97601
35. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)

CAUSE OF DEATH

CONDITIONS IF ANY WHICH GIVE RISE TO IMMEDIATE CAUSE STATING THE UNDERLYING CAUSE LAST

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) Respiratory + Renal Failure — Interval between onset and death: 1 wk.
DUE TO, OR AS A CONSEQUENCE OF:
(b) Lung Tumor, Congestive Heart Failure — Interval between onset and death:
DUE TO, OR AS A CONSEQUENCE OF:
(c) — Interval between onset and death:

PART II OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not related to cause given in PART I.
Atrial Fib Pacemaker
37. Did tobacco use contribute to the death? ☐ Yes ☐ No X Probably ☐ Unk
38. AUTOPSY ☐ Yes X No
39. If YES were findings considered in determining cause of death? ☐ Yes ☐ No ☐ N/A

40. MANNER OF DEATH: X Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Undetermined Manner ☐ Legal Intervention
41a. DATE OF INJURY (Month, Day, Year)
41b. TIME OF INJURY M
41c. INJURY AT WORK? ☐ Yes ☐ 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)

RESERVED FOR REGISTRAR'S USE

45-2 REV. 1-89

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 APR 14 1989

Marian Ackerman
MARIAN ACKERMAN
COUNTY REGISTRAR
KLAMATH COUNTY, OREGON

STATE OF OREGON: COUNTY OF KLAMATH: ss.

Filed for record at request of Dorothy Ewing the 21st day of April A.D., 19 89 at 12:55 o'clock P.M., and duly recorded in Vol. M89, of Deeds on Page 6756.

Evelyn Biehn County Clerk
By Pauline Millenbach

FEE $8.00
Return: Dorothy Ewing
5304 Alva, Klamath Falls, Or. 97603