

2136

OFFICE OF THE DEPARTMENT OF HUMAN RESOURCES
HEALTH DIVISION
Vital Records Unit
CERTIFICATE OF DEATH

Vol. m89 Page 11840

PRINT IN
PERMANENT
BLACK INK

55813

LD. TAG NO.

318

Local File Number

136-

State File Number

DECEDENT

PARENTS

DISPOSITION

REGISTRAR

CERTIFIER

CAUSE OF DEATH

1. DECEDENT'S NAME First Middle Last Elwood Charles YOUNG		2. SEX M	3. DATE OF DEATH (Month, Day, Year) June 26, 1989
4. SOCIAL SECURITY NUMBER 540 34 0440		5a. AGE - Last Birth (Years) 61	5b. Under 1 Year Mcs. Days Hours Mins.
6. BIRTHPLACE (City and State or Foreign Country) Gaylor, Oregon		7. DATE OF BIRTH (Month, Day, Year) October 10, 1927	
8. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Location: <input type="checkbox"/> EFO 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)			
9. FACILITY NAME (If not institution, give street and number) St. Charles Medical Center		10. CITY, TOWN, OR LOCATION OF DEATH Bend	
11. COUNTY OF DEATH Deschutes		12. MARITAL STATUS - Married, Never Married, Widowed, Divorced (Specify) Married	
13. SPOUSE (If Married, Widowed) Audrey		14. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use title) Owner Remanufacturing Plant	
15. KIND OF BUSINESS/INDUSTRY Wood		16. CITY, TOWN, OR LOCATION Crescent	
17. RESIDENCE - STATE Oregon		18. COUNTY Klamath	
19. INSIDE CITY LIMITS? 97733		20. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.) No	
21. RACE American Indian, Black, White, etc. (Specify) White		22. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (5-12) College (1-4 or 5+) 12	
23. FATHER - NAME first middle last Fay Arthur Young		24. MOTHER - NAME first middle maiden Oma Christina Grant	
25. INFORMANT - NAME and relationship to deceased Audrey Young Wife		26. LOCATION - City or Town, State Bend, Oregon	
27. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Mausoleum <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Deschutes Memorial Gardens		28. LICENSE NUMBER (Of Licensee) 3331	
29. NAME, ADDRESS AND ZIP OF FACILITY Niswonger-Reynolds, Inc. 105 N.W. Irving Bend, OR 97701		30. REGISTRAR'S SIGNATURE Jacqueline Mathis, Dep.	
31. DATE FILED (Month, Day, Year) June 27, 1989		32. WAS GIFT MADE? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> N/A	
33. HOSPITAL REPRESENTATIVE MAKE REQUEST FOR ANATOMICAL GIFT CONSENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A		34. TO BE COMPLETED ONLY BY MEDICAL EXAMINER 31a. TIME OF DEATH 31b. DATE PRONOUNCED DEAD (Month, Day, Year, Hour) M	
35. TO BE COMPLETED BY CERTIFYING PHYSICIAN 35a. TIME OF DEATH 35b. WAS MEDICAL EXAMINER NOTIFIED? 35c. To the best of my knowledge, death occurred at the time, date, place and due to the cause recorded in this manner (Signature) David A. Fredstrom, M.D. 6-27-89		36. 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) 37. DATE SIGNED (Month, Day, Year) COUNTY	
38. NAME, TITLE, ADDRESS AND ZIP OF CERTIFIER/MEDICAL EXAMINER (Type or Print) David A. Fredstrom, M.D. 361 N. E. Franklin Bend, OR 97701		39. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)	
40. IMMEDIATE CAUSE (ENTER ONLY - DO NOT USE PER LINE FOR (a), (b), AND (c). Do not enter mode of dying, e.g. Cardiac or Respiratory Arrest.) PART I (a) Liver failure DUE TO, OR AS A CONSEQUENCE OF: (b) Hemorrhage as a result DUE TO, OR AS A CONSEQUENCE OF: (c) OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not related to cause given in PART I.		41. Old tobacco use contribute to the death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown 42. AUTOPSY <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 43. If YES, how findings contributed to determining cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> N/A	
44. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Undetermined <input type="checkbox"/> Suicide <input type="checkbox"/> Legal Intervention <input type="checkbox"/> Homicide		45. DATE OF INJURY (Month, Day, Year) 46. TIME OF INJURY M <input type="checkbox"/> Yes <input type="checkbox"/> No 47. INJURY AT WORK? M <input type="checkbox"/> Yes <input type="checkbox"/> No	
48. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)		49. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

ORIGINAL - VITAL STATISTICS COPY

45-2 REV. 1-89

STATE OF OREGON, COUNTY OF DESCHUTES

I HEREBY CERTIFY THAT THE FOREGOING COPY HAS BEEN COMPARED BY ME WITH THE ORIGINAL DOCUMENT AND IS A TRUE, FULL AND CORRECT COPY OF THE ORIGINAL CERTIFICATE AS THE SAME APPEARS ON FILE IN THE VITAL RECORDS UNIT OF THE DESCHUTES COUNTY HEALTH DEPARTMENT AND IN MY OFFICIAL CARE AND CUSTODY.

NOT VALID WITHOUT RAISED SEAL OF
DESCHUTES COUNTY HEALTH DEPARTMENT

JACQUELINE MATHIS, DEPUTY REGISTRAR

DATE

Return: Niswonger-Reynolds, Inc.
105 N.W. Irving;
Bend, Or. 97701.STATE OF OREGON, ss.
County of Klamath

Filed for record at request of:

Niswonger-Reynolds Inc.
on this 30th day of June A.D., 1989
at 11:37 o'clock AM. and duly recorded
in Vol. M89 of Deeds Page 11840
Evelyn Biehn County Clerk
By Russell Mendenhall
Deputy.

Fee, \$8.00