

D-5579  
I.D. TAG NO.  
439  
Local File Number

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

136

State File Number

1. DECEDENT'S NAME First: Roy Middle: Thomas Last: RUGE		2. SEX M	3. DATE OF DEATH (Month, Day, Year) October 8, 1989
4. SOCIAL SECURITY NUMBER 502-07-6019	5a. AGE - Last Birthday (Years) 75	5b. Under 1 Year Mos. Days Hours Mins.	6. BIRTHPLACE (City and State or Foreign Country) Minot, N. Dakota
7. DATE OF BIRTH (Month, Day, Year) February 27, 1914		8. PLACE OF DEATH (Check only one) <input type="checkbox"/> Hospital <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> Other: Nursing Home <input type="checkbox"/> Decedent's Home <input type="checkbox"/> Other (Specify)	
9a. FACILITY NAME (If not institution, give street and number) Merle West Medical Center		9b. 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.) Jeweler		10b. KIND OF BUSINESS/INDUSTRY Jewelry Store Owner	
11. MARITAL STATUS - Married, Never Married, Widowed, Divorced (Specify) Married		12. SPOUSE (If Married, Widowed) Viola I.	
13a. RESIDENCE - STATE Oregon		13b. COUNTY Klamath	
13c. CITY, TOWN, OR LOCATION Klamath Falls		13d. STREET AND NUMBER 6080 South Sixth Street	
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 (8-12) College (1-4 or 5+) 8		17. FATHER - NAME first middle last Indolph Ruge	
18. MOTHER - NAME first middle maiden Phema Reno		19. INFORMANT - NAME and relationship to deceased Viola I. Ruge, 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)		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 William J. Davenport		21b. LICENSE NUMBER (Of Licensee) 47-3104	
22. NAME, ADDRESS AND ZIP OF FACILITY Davenport's Chapel of the Good Shepherd, 6420 So. 6th St., Klamath Falls, Oregon 97603-7194		23. DATE FILED (Month, Day, Year) Oct 9 1989	
24. REGISTRAR'S SIGNATURE Randy Kennedy		25. DID HOSPITAL REPRESENTATIVE MAKE REQUEST FOR ANATOMICAL GIFT CONSENT? <input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> N/A	
26. TO BE COMPLETED BY CERTIFYING PHYSICIAN 27. TIME OF DEATH M <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		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) Jon G. McKellar		30. DATE SIGNED (Month, Day, Year) October 9, 1989	
31. NAME, TITLE, ADDRESS AND ZIP OF CERTIFYING MEDICAL EXAMINER (Type or Print) Jon G. McKellar, MD, ME, 2300 Clairmont, Klamath Falls, Oregon 97601		32. NAME, ADDRESS AND ZIP OF FACILITY Davenport's Chapel of the Good Shepherd, 6420 So. 6th St., Klamath Falls, Oregon 97603-7194	
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) Self-inflicted gunshot wound (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.		34. DATE SIGNED (Month, Day, Year) October 9, 1989	
35. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Undetermined <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Legal Intervention <input type="checkbox"/> Homicide		36. DATE OF INJURY (Month, Day, Year) 10/08/89	
37. TIME OF INJURY 1310 PM		38. INJURY AT WORK? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
39. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify) Home		40. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6080 So. 6th St., Klamath Falls, OR 97603	
41. DESCRIBE HOW INJURY OCCURRED Self-inflicted GSW to head: 38 Caliber		42. DATE SIGNED (Month, Day, Year) October 9, 1989	
43. TO BE COMPLETED ONLY BY MEDICAL EXAMINER 44. TIME OF DEATH 1800 P M		45. DATE PRONOUNCED DEAD (Month, Day, Year, Hour) October 8, 1989 1800 PM	
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