

## CERTIFICATION OF VITAL RECORD

068578  
I.D. TAG NO.464  
Local File NumberHEALTH DIVISION  
Vital Records Unit  
CERTIFICATE OF DEATH

136-

State File Number

DECEDENT

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1. DECEDENT'S NAME First: Virginia Middle: K. Last: TOFELL			2. SEX F		3. DATE OF DEATH (Month, Day, Year) October 21, 1989	
4. SOCIAL SECURITY NUMBER 542-48-5928			5a. AGE - Last Birthday (Years) 74		5b. Under 1 Year Mos. Days Hours Mins.	
6. BIRTHPLACE (City and State or Foreign Country) Dodge City, Kansas			7. DATE OF BIRTH (Month, Day, Year) September 24, 1915			
8. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
9a. PLACE OF DEATH (Check only one) <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Decedent's Home <input type="checkbox"/> Other (Specify)						
9b. COUNTY OF DEATH Klamath						
9c. CITY, TOWN, OR LOCATION OF DEATH Klamath Falls						
10. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) Homemaker						
10b. KIND OF BUSINESS/INDUSTRY Own Home						
11. MARITAL STATUS - Married, Never Married, Widowed, Divorced (Specify) Married						
12. SPOUSE (If Married, Widowed) Frank						
13a. RESIDENCE - STATE Oregon						
13b. COUNTY Klamath						
13c. CITY, TOWN, OR LOCATION Klamath Falls						
13d. STREET AND NUMBER 6261 Juniper Way						
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+) 12						
17. FATHER - NAME first middle last William - Smith						
18. MOTHER - NAME first middle maiden Maud - Mason						
19. INFORMANT - NAME and relationship to decedent Frank Tofell, husband						
20. LOCATION - City or Town, State Malin, Oregon						
21. 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)						
22. NAME, ADDRESS AND ZIP OF FACILITY O'Hair's Funeral Chapel, Inc. 515 Pine St., Klamath Falls, OR 97601						
23. DATE FILED (Month, Day, Year) OCT 24 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						

PARENTS

DISPOSITION

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