

CERTIFICATION OF VITAL RECORD

OREGON DEPARTMENT OF HUMAN RESOURCES

HEALTH DIVISION
Vital Records Unit

CERTIFICATE OF DEATH

State File Number

068231
I.D. TAG NO.557
Local File Number

136-

1. DECEDENT'S First Name Alford Eugene HAZZARD		2. SEX Male	3. DATE OF DEATH (Month, Day, Year) December 24, 1989
4. SOCIAL SECURITY NUMBER 543-09-4502		5a. AGE - Last Birthday (Years) 80	5b. Under 1 Year Mos. Days Hours Mins.
6. BIRTHPLACE (City and State or Foreign Country) Salt Lake City, Utah		7. DATE OF BIRTH (Month, Day, Year) November 1, 1909	
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 type="checkbox"/> Hospital <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> Other (Specify) Foster Care			
9b. FACILITY NAME (If not institution, give street and number) 1919 Bryant Ct.		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.) Millwright		10b. KIND OF BUSINESS/INDUSTRY Weyerhaeuser Co.	
11. MARITAL STATUS - Married, Never Married, Widowed, Divorced (Specify) Widowed		12. SPOUSE (If Married, Widowed) Frances	
13a. RESIDENCE - STATE Oregon		13b. COUNTY Klamath	
13c. CITY, TOWN, OR LOCATION Klamath Falls		13d. STREET AND NUMBER 1606 Wiard St.	
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 Specify:		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+) 8		17. FATHER - Name first middle last Ira Hap Hazzard	
18. MOTHER - Name first middle maiden Bertha Hutchinson		19. INFORMANT - Name and relationship to decedent Lee-Ila Perry - Daughter	
20a. METHOD OF DISPOSITION <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) Klamath Memorial Park	
21a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH Jim Lancaster		21b. LICENSE NUMBER (Of licensee) 3224	
22. NAME, ADDRESS AND ZIP OF FACILITY WARD'S Funeral Home/ 1945 Main St. Klamath Falls, Oregon 97601		23. DATE FILED (Month, Day, Year) JAN 2 1990	
24. REGISTRAR'S SIGNATURE Nancy 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. WAS GIFT MADE? <input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> N/A			
TO BE COMPLETED BY CERTIFYING PHYSICIAN			
27. TIME OF DEATH 9:30 A 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) Kenneth K. Magee			
30. DATE SIGNED (Month, Day, Year) JAN 2 1990			
31. NAME, TITLE, ADDRESS AND ZIP OF CERTIFIER/MEDICAL EXAMINER (Type or Print) Kenneth K. Magee, MD - 1900 Main St. - Klamath Falls, Ore. 97601			
32. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)			
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.)			
(a) Coronary Heart Failure			
(b) Coronary Atherosclerosis & Valvular Heart Disease			
(c) Myocardial Infarction			
34. OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not related to cause given in PART I. Chronic Kidney Disease			
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) 12/24/89			
37. TIME OF INJURY 9:30 A M			
38. INJURY AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unk			
39. DESCRIBE HOW INJURY OCCURRED			
40. PLACE OF INJURY - At home, farm, street, factory, office, building, etc. (Specify) At home			
41. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
42. DATE SIGNED (Month, Day, Year)			
43. COUNTY			
44. NAME, TITLE, ADDRESS AND ZIP OF CERTIFIER/MEDICAL EXAMINER (Type or Print)			
45. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)			
46. 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) Coronary Heart Failure			
(b) Coronary Atherosclerosis & Valvular Heart Disease			
(c) Myocardial Infarction			
47. OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not related to cause given in PART I. Chronic Kidney Disease			
48. 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			
49. DATE OF INJURY (Month, Day, Year) 12/24/89			
50. TIME OF INJURY 9:30 A M			
51. INJURY AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unk			
52. DESCRIBE HOW INJURY OCCURRED			
53. PLACE OF INJURY - At home, farm, street, factory, office, building, etc. (Specify) At home			
54. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
55. DATE SIGNED (Month, Day, Year)			
56. COUNTY			
57. NAME, TITLE, ADDRESS AND ZIP OF CERTIFIER/MEDICAL EXAMINER (Type or Print)			
58. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)			
59. 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) Coronary Heart Failure			
(b) Coronary Atherosclerosis & Valvular Heart Disease			
(c) Myocardial Infarction			
60. OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not related to cause given in PART I. Chronic Kidney Disease			
61. 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			
62. DATE OF INJURY (Month, Day, Year) 12/24/89			
63. TIME OF INJURY 9:30 A M			
64. INJURY AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unk			
65. DESCRIBE HOW INJURY OCCURRED			
66. PLACE OF INJURY - At home, farm, street, factory, office, building, etc. (Specify) At home			
67. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
68. DATE SIGNED (Month, Day, Year)			
69. COUNTY			
70. NAME, TITLE, ADDRESS AND ZIP OF CERTIFIER/MEDICAL EXAMINER (Type or Print)			
71. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)			
72. 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) Coronary Heart Failure			
(b) Coronary Atherosclerosis & Valvular Heart Disease			
(c) Myocardial Infarction			
73. OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not related to cause given in PART I. Chronic Kidney Disease			
74. 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			
75. DATE OF INJURY (Month, Day, Year) 12/24/89			
76. TIME OF INJURY 9:30 A M			
77. INJURY AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unk			
78. DESCRIBE HOW INJURY OCCURRED			
79. PLACE OF INJURY - At home, farm, street, factory, office, building, etc. (Specify) At home			
80. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
81. DATE SIGNED (Month, Day, Year)			
82. COUNTY			
83. NAME, TITLE, ADDRESS AND ZIP OF CERTIFIER/MEDICAL EXAMINER (Type or Print)			
84. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)			
85. 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) Coronary Heart Failure			
(b) Coronary Atherosclerosis & Valvular Heart Disease			
(c) Myocardial Infarction			
86. OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not related to cause given in PART I. Chronic Kidney Disease			
87. 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			
88. DATE OF INJURY (Month, Day, Year) 12/24/89			
89. TIME OF INJURY 9:30 A M			
90. INJURY AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unk			
91. DESCRIBE HOW INJURY OCCURRED			
92. PLACE OF INJURY - At home, farm, street, factory, office, building, etc. (Specify) At home			
93. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
94. DATE SIGNED (Month, Day, Year)			
95. COUNTY			
96. NAME, TITLE, ADDRESS AND ZIP OF CERTIFIER/MEDICAL EXAMINER (Type or Print)			
97. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)			
98. 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) Coronary Heart Failure			
(b) Coronary Atherosclerosis & Valvular Heart Disease			
(c) Myocardial Infarction			
99. OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not related to cause given in PART I. Chronic Kidney Disease			
100. 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			
101. DATE OF INJURY (Month, Day, Year) 12/24/89			
102. TIME OF INJURY 9:30 A M			
103. INJURY AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unk			
104. DESCRIBE HOW INJURY OCCURRED			
105. PLACE OF INJURY - At home, farm, street, factory, office, building, etc. (Specify) At home			
106. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
107. DATE SIGNED (Month, Day, Year)			
108. COUNTY			
109. NAME, TITLE, ADDRESS AND ZIP OF CERTIFIER/MEDICAL EXAMINER (Type or Print)			
110. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)			
111. 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) Coronary Heart Failure			
(b) Coronary Atherosclerosis & Valvular Heart Disease			
(c) Myocardial Infarction			
112. OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not related to cause given in PART I. Chronic Kidney Disease			
113. 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			
114. DATE OF INJURY (Month, Day, Year) 12/24/89			
115. TIME OF INJURY 9:30 A M			
116. INJURY AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unk			
117. DESCRIBE HOW INJURY OCCURRED			
118. PLACE OF INJURY - At home, farm, street, factory, office, building, etc. (Specify) At home			
119. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
120. DATE SIGNED (Month, Day, Year)			
121. COUNTY			
122. NAME, TITLE, ADDRESS AND ZIP OF CERTIFIER/MEDICAL EXAMINER (Type or Print)			
123. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)			
124. 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) Coronary Heart Failure			
(b) Coronary Atherosclerosis & Valvular Heart Disease			
(c) Myocardial Infarction			
125. OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not related to cause given in PART I. Chronic Kidney Disease			
126. 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			
127. DATE OF INJURY (Month, Day, Year) 12/24/89			
128. TIME OF INJURY 9:30 A M			
129. INJURY AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unk			
130. DESCRIBE HOW INJURY OCCURRED			
131. PLACE OF INJURY - At home, farm, street, factory, office, building, etc. (Specify) At home			
132. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
133. DATE SIGNED (Month, Day, Year)			
134. COUNTY			
135. NAME, TITLE, ADDRESS AND ZIP OF CERTIFIER/MEDICAL EXAMINER (Type or Print)			
136. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)			
137. 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) Coronary Heart Failure			
(b) Coronary Atherosclerosis & Valvular Heart Disease			
(c) Myocardial Infarction			
138. OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not related to cause given in PART I. Chronic Kidney Disease			
139. 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			
140. DATE OF INJURY (Month, Day, Year) 12/24/89			
141. TIME OF INJURY 9:30 A M			
142. INJURY AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unk			
143. DESCRIBE HOW INJURY OCCURRED			
144. PLACE OF INJURY - At home, farm, street, factory, office, building, etc. (Specify) At home			
145. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
146. DATE SIGNED (Month, Day, Year)			
147. COUNTY			
148. NAME, TITLE, ADDRESS AND ZIP OF CERTIFIER/MEDICAL EXAMINER (Type or Print)			
149. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)			
150. 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) Coronary Heart Failure			
(b) Coronary Atherosclerosis & Valvular Heart Disease			
(c) Myocardial Infarction			
151. OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not related to cause given in PART I. Chronic Kidney Disease			
152. 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			
153. DATE OF INJURY (Month, Day, Year) 12/24/89			
154. TIME OF INJURY 9:30 A M			
155. INJURY AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unk			
156. DESCRIBE HOW INJURY OCCURRED			
157. PLACE OF INJURY - At home, farm, street, factory, office, building, etc. (Specify) At home			
158. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
159. DATE SIGNED (Month, Day, Year)			
160. COUNTY			
161. NAME, TITLE, ADDRESS AND ZIP OF CERTIFIER/MEDICAL EXAMINER (Type or Print)			
162. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)			
163. 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) Coronary Heart Failure			
(b) Coronary Atherosclerosis & Valvular Heart Disease			
(c) Myocardial Infarction			
164. OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not related to cause given in PART I. Chronic Kidney Disease			
165. 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			
166. DATE OF INJURY (Month, Day, Year) 12/24/89			
167. TIME OF INJURY 9:30 A M			
168. INJURY AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unk			
169. DESCRIBE HOW INJURY OCCURRED			
170. PLACE OF INJURY - At home, farm, street, factory, office, building, etc. (Specify) At home			
171. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
172. DATE SIGNED (Month, Day, Year)			
173. COUNTY			
174. NAME, TITLE, ADDRESS AND ZIP OF CERTIFIER/MEDICAL EXAMINER (Type or Print)			
175. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)			
176. 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) Coronary Heart Failure			
(b) Coronary Atherosclerosis & Valvular Heart Disease			
(c) Myocardial Infarction			
177. OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not related to cause given in PART I. Chronic Kidney Disease			
178. 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			
179. DATE OF INJURY (Month, Day, Year) 12/24/89			
180. TIME OF INJURY 9:30 A M			
181. INJURY AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unk			
182. DESCRIBE HOW INJURY OCCURRED			
183. PLACE OF INJURY - At home, farm, street, factory, office, building, etc. (Specify) At home			
184. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
185. DATE SIGNED (Month, Day, Year)			
186. COUNTY			
187. NAME, TITLE, ADDRESS AND ZIP OF CERTIFIER/MEDICAL EXAMINER (Type or Print)			
188. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)			
189. 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) Coronary Heart Failure			
(b) Coronary Atherosclerosis & Valvular Heart Disease			
(c) Myocardial Infarction			
190. OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not related to cause given in PART I. Chronic Kidney Disease			
191. 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			
192. DATE OF INJURY (Month, Day, Year) 12/24/89			
193. TIME OF INJURY 9:30 A M			
194. INJURY AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unk			
195. DESCRIBE HOW INJURY OCCURRED			
196. PLACE OF INJURY - At home, farm, street, factory, office, building, etc. (Specify) At home			
197. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
198. DATE SIGNED (Month, Day, Year)			
199. COUNTY			
200. NAME, TITLE, ADDRESS AND ZIP OF CERTIFIER/MEDICAL EXAMINER (Type or Print)			
201. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)			
202. 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) Coronary Heart Failure			
(b) Coronary Atherosclerosis & Valvular Heart Disease			
(c) Myocardial Infarction			
203. OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not related to cause given in PART I. Chronic Kidney Disease			
204. 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			
205. DATE OF INJURY (Month, Day, Year) 12/24/89			
206. TIME OF INJURY 9:30 A M			
207. INJURY AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unk			
208. DESCRIBE HOW INJURY OCCURRED			
209. PLACE OF INJURY - At home, farm, street, factory, office, building, etc. (Specify) At home			
210. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
211. DATE SIGNED (Month, Day, Year)			
212. COUNTY			
213. NAME, TITLE, ADDRESS AND ZIP OF CERTIFIER/MEDICAL EXAMINER (Type or Print)			
214. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)			
215. 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) Coronary Heart Failure			
(b) Coronary Atherosclerosis & Valvular Heart Disease			
(c) Myocardial Infarction			
216. OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not related to cause given in PART I. Chronic Kidney Disease			
217. 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			
218. DATE OF INJURY (Month, Day, Year) 12/24/89			
219. TIME OF INJURY 9:30 A M			
220. INJURY AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unk			
221. DESCRIBE HOW INJURY OCCURRED			
222. PLACE OF INJURY - At home, farm, street, factory, office, building, etc. (Specify) At home			
223. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
224. DATE SIGNED (Month, Day, Year)			
225. COUNTY			
226. NAME, TITLE, ADDRESS AND ZIP OF CERTIFIER/MEDICAL EXAMINER (Type or Print)			
227. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)			
228. 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) Coronary Heart Failure			
(b) Coronary Atherosclerosis & Valvular Heart Disease			
(c) Myocardial Infarction			
229. OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not related to cause given in PART I. Chronic Kidney Disease			
230. 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			
231. DATE OF INJURY (Month, Day, Year) 12/24/89			
232. TIME OF INJURY 9:30 A M			
233. INJURY AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unk			
234. DESCRIBE HOW INJURY OCCURRED			
235. PLACE OF INJURY - At home, farm, street, factory, office, building, etc. (Specify) At home			
236. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
237. DATE SIGNED (Month, Day, Year)			
238. COUNTY			
239. NAME, TITLE, ADDRESS AND ZIP OF CERTIFIER/MEDICAL EXAMINER (Type or Print)			
240. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)			
241. 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) Coronary Heart Failure			
(b) Coronary Atherosclerosis & Valvular Heart Disease			
(c) Myocardial Infarction			
242. OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not related to cause given in PART I. Chronic Kidney Disease			
243. 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			
244. DATE OF INJURY (Month, Day, Year) 12/24/89			
245. TIME OF INJURY 9:30 A M			
246. INJURY AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unk			
247. DESCRIBE HOW INJURY OCCURRED			
248. PLACE OF INJURY - At home, farm, street, factory, office, building, etc. (Specify) At home			
249. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
250. DATE SIGNED (Month, Day, Year)			
251. COUNTY			
252. NAME, TITLE, ADDRESS AND ZIP OF CERTIFIER/MEDICAL EXAMINER (Type or Print)			
253. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)			
254. 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) Coronary Heart Failure			
(b) Coronary Atherosclerosis & Valvular Heart Disease			
(c) Myocardial Infarction			
255. OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not related to cause given in PART I. Chronic Kidney Disease			