

CERTIFICATION OF VITAL RECORD

079725

I.D. TAG NO.

277

Local File Number

OREGON DEPARTMENT OF HUMAN RESOURCES

HEALTH DIVISION

Vital Records Unit

CERTIFICATE OF DEATH

136-

State File Number

DECEDENT

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PARENTS

DISPOSITION

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8

9

REGISTRAR

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11

CERTIFIER

12

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14

CAUSE OF DEATH

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

CAUSE OF DEATH

15

16

17

1. DECEDENT'S NAME First: <u>Dick</u> Middle: <u>Lane</u> Last: <u>OWENS</u>			2. SEX <u>M</u>	3. DATE OF DEATH (Month, Day, Year) <u>June 29, 1990</u>
4. SOCIAL SECURITY NUMBER <u>543-10-4329</u>		5a. AGE - Last Birthday (Years) <u>74</u>	5b. Under 1 Year Mos. Days Hours Mins.	6. BIRTHPLACE (City and State or Foreign Country) <u>Klamath Falls, OR</u>
8. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> Yes <input 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 type="checkbox"/> Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Decedent's Home <input type="checkbox"/> Other (Specify)		
9b. FACILITY NAME (if not institution, give street and number) <u>6803 Shasta Way</u>			9c. CITY, TOWN, OR LOCATION OF DEATH <u>Klamath Falls</u>	
10a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) <u>Farmer</u>			10b. KIND OF BUSINESS/INDUSTRY <u>Farming</u>	
11. MARITAL STATUS - Married, Never Married, Widowed, Divorced (Specify) <u>Married</u>			12. SPOUSE (if Married, Widowed) <u>Lenore Owens</u>	
13a. RESIDENCE - STATE <u>Oregon</u>		13b. COUNTY <u>Klamath</u>		13c. CITY, TOWN, OR LOCATION <u>Klamath Falls</u>
13d. STREET AND NUMBER <u>6803 Shasta Way</u>				
13e. INSIDE CITY LIMITS? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		13f. ZIP CODE <u>97603</u>		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) <u>White</u>		16. DECEDENT'S EDUCATION (Specify only highest grade completed) <u>Elementary/Secondary (8-12)</u>		
17. FATHER - NAME first middle last <u>Tom - Owens</u>			18. MOTHER - NAME first middle maiden <u>Elsie - Dixon</u>	
19. INFORMANT - NAME and relationship to decedent <u>Lenore Owens, wife</u>			20. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) <u>Eternal Hills Memorial Gardens</u>	
21a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH <u>Merrell Reid</u>			21b. LICENSE NUMBER (Of Licensee) <u>3329</u>	
22. NAME, ADDRESS AND ZIP OF FACILITY <u>O'Hair's Funeral Chapel, Inc. 515 Pine St., Klamath Falls, OR 97601</u>				
23. DATE FILED (Month, Day, Year) <u>JUL 5 1990</u>			24. REGISTRAR'S SIGNATURE <u>Dancer Kennedy</u>	
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 <u>7:40 P.</u>		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) <u>Randal A. Machado</u> M.D.				
30. DATE SIGNED (Month, Day, Year) <u>July 2, 1990</u>				
31. NAME, TITLE, ADDRESS AND ZIP OF CERTIFIER/MEDICAL EXAMINER (Type or Print) <u>Randal A. Machado, M.D., 1905 Main Street, Klamath Falls, Oregon 97601</u>				
32. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)				
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) <u>Respiratory Failure</u>				
(b) <u>Myocardial Infarction</u>				
(c) <u>Cerebral Vascular Accident</u>				
PART II OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not related to cause given in PART I. <u>Cerebral Vascular Accident</u>				
37. Did tobacco use contribute to the death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
38. AUTOPSY <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
39. If YES were findings considered in determining cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> N/A				
40. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accidental <input type="checkbox"/> Undetermined <input type="checkbox"/> Suicide <input type="checkbox"/> Legal Intervention <input type="checkbox"/> Homicide				
41a. DATE OF INJURY (Month, Day, Year)				
41b. TIME OF INJURY <u>M</u> <input type="checkbox"/> Yes <input type="checkbox"/> No				
41c. INJURY AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> 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)				

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ORIGINAL - VITAL STATISTICS COPY

45-2 REV. 1-85

THIS IS A TRUE AND EXACT REPRODUCTION OF THE DOCUMENT OFFICIALLY REGISTERED AT THE OFFICE OF THE KLAMATH COUNTY REGISTRAR.

DATE ISSUED JUL 5 1990Donna A. Verling
DONNA A. VERLING
COUNTY REGISTRAR
KLAMATH COUNTY, OREGON

STATE OF OREGON: COUNTY OF KLAMATH: ss.

Filed for record at request of Aspen Title Co. the 28th day of Dec. A.D., 19 90 at 10:33 o'clock A M., and duly recorded in Vol. M90 of Deeds on Page 25545

FEE \$8.00

Return: Lenore Owens

6803 Shasta Way, Klamath Falls, OR. 97601

Evelyn Biehn County Clerk

By Donna A. Verling