

I.D. TAG NO.

HEALTH DIVISION
CENTER FOR HEALTH STATISTICS
CERTIFICATE OF DEATH

State File Number

Local File Number

1. DECEDENT'S NAME First: Helen Middle: Frances Last: WADE		2. SEX Female	3. DATE OF DEATH (Month, Day, Year) January 25, 1992
4. SOCIAL SECURITY NUMBER 491-40-5219		5. AGE Last Birthday (Years) 55	6. BIRTHPLACE (City and State or Foreign Country) Eggerton, MO
7. DATE OF BIRTH (Month, Day, Year) August 13, 1936		8. PLACE OF DEATH (Check only one) <input type="checkbox"/> Hospital <input checked="" type="checkbox"/> 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) Merle West Medical Center		10. CITY, TOWN, OR LOCATION OF DEATH Klamath Falls	
11. MARITAL STATUS - Married, Never Married, Widowed, Divorced (Specify) Married		12. SPOUSE (If Married, Widowed) Phillip N. Wade	
13. RESIDENCE - STATE Oregon		14. RESIDENCE - CITY, TOWN OR LOCATION Klamath Falls	
15. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		16. ZIP CODE 97603	
17. FATHER - NAME first middle last Lawson E. Rice		18. MOTHER - NAME first middle maiden Susie M. Martin	
19. 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)		20. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) Eternal Hills Memorial Gardens	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH <i>James O. Figg</i>		22. LICENSE NUMBER (Of Licensee) 49-1275	
23. DATE FILED (Month, Day, Year) JAN 28 1992		24. REGISTRAR'S SIGNATURE <i>Charles Barcus</i>	
25. DID HOSPITAL REPRESENTATIVE MAKE REQUEST FOR ANATOMICAL GIFT CONSENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> N/A		26. WAS GIFT MADE? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> N/A	
27. TIME OF DEATH 7:55 P.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) <i>Earle M. LeVernois</i> M.D.			
30. DATE SIGNED (Month, Day, Year) JAN 27 '92			
31. NAME, TITLE, ADDRESS AND ZIP OF CERTIFYING MEDICAL EXAMINER (Type or Print) Earle M. LeVernois M.D. 2628 Campus Drive, Klamath Falls, Oregon 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) Massive Pulmonary Embolus (b) Deep Venous Thrombosis (c) Post op Repair Stomach Intest Vent Hernia			
34. INTERVAL BETWEEN ONSET AND DEATH Unknown			
35. INTERVAL BETWEEN ONSET AND DEATH Unknown			
36. INTERVAL BETWEEN ONSET AND DEATH Unknown			
37. Did tobacco use contribute to the death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
38. AUTOPSY <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A			
39. H YES were findings considered in determining cause of death?			
40. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accidental <input type="checkbox"/> Undetermined Manner <input type="checkbox"/> Suicide <input type="checkbox"/> Legal Intervention <input type="checkbox"/> Homicide			
41. DATE OF INJURY (Month, Day, Year) M			
42. INJURY AT WORK? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
43. DESCRIBE HOW INJURY OCCURRED			
44. PLACE OF INJURY - At home, farm, street, factory, office building etc. (Specify)			
45. LOCATION (Street and Number or Rural Route Number, City or Town, State)			

ORIGINAL-VITAL STATISTICS COPY

THIS IS A TRUE AND EXACT REPRODUCTION OF THE DOCUMENT OFFICIALLY
REGISTERED AT THE OFFICE OF THE KLAMATH COUNTY REGISTRAR.DATE ISSUED **JAN 28 1992**DONNA A. VERLING
COUNTY REGISTRAR
KLAMATH COUNTY, OREGON

STATE OF OREGON: COUNTY OF KLAMATH: 88

Filed for record at request of **Phillip Wade** the **12th** day
of **Feb.** A.D., 19 **92** at **2:51** o'clock **P.M.**, and duly recorded in Vol. **M92**
of **Deeds** on Page **2959**Evelyn Biehn County Clerk
By *Donna A. Verling*

FEE \$10.00

Return: Phillip Wade
1736 Chincalla Way, Klamath Falls, Or. 97603