

43116

OREGON HEALTH DIVISION  
CENTER FOR HEALTH STATISTICSIN-  
KENT  
INK7-6418  
LD. TAG NO.  
**911129**  
Local File NumberOREGON DEPARTMENT OF HUMAN RESOURCES  
HEALTH DIVISION  
CENTER FOR HEALTH STATISTICS  
CERTIFICATE OF DEATH

91-020247

State File Number

|  |  |  |   |
|--|--|--|---|
| 1. DECEDENT'S NAME<br>First: <b>Phil</b> Middle: <b>Edward</b> Last: <b>POWLER</b>   |  | 2. SEX<br><b>Male</b>  | 3. DATE OF DEATH (Month, Day, Year)<br><b>October 17, 1991</b>      |
| 4. SOCIAL SECURITY NUMBER<br><b>564-52-8107</b>  | 5a. AGE-Last Birthday (Years)<br><b>46</b> | 5b. Under 1 Year<br>Mos. <b>4</b> Days <b>1</b> Hours <b>1</b> Mins. <b>1</b>  | 6. BIRTHPLACE (City and State or Foreign Country)<br><b>Unknown</b> |
| 7. DATE OF BIRTH (Month, Day, Year)<br><b>April 15, 1947</b>   |  | 8. PLACE OF DEATH (Check only one)<br><input checked="" type="checkbox"/> Home <b>66</b>                                   |   |
| 9. FACILITY NAME (If not institution, give street and number)<br><b>Hwy. 66, Mile 19</b>   |  | 10. CITY, TOWN, OR LOCATION OF DEATH<br><b>Ashland</b>   |   |
| 11. MARITAL STATUS: Married, Never Married, Widowed, Divorced (Specify)<br><b>Divorced</b>   |  | 12. SPOUSE (If Married, Widowed, Divorced) (Specify)<br><b>William 19</b>  |   |
| 13a. RESIDENCE - STATE<br><b>Oregon</b>  |  | 13b. COUNTY<br><b>Klamath</b>  |   |
| 13c. CITY, TOWN OR LOCATION<br><b>Klamath Falls</b>  |  | 13d. STREET AND NUMBER<br><b>4665 Pack Dr.</b>   |   |
| 14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes; if Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input checked="" type="checkbox"/> No   |  | 15. RACE American Indian, Black, White, etc. (Specify)<br><b>White</b>   |   |
| 16. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (1-12) College (1-4 or 5+)<br><b>Elementary</b>  |  | 17. FATHER - NAME first middle last<br><b>Unknown</b>  |   |
| 18. MOTHER - NAME first middle maiden<br><b>Unknown</b>  |  | 19. INFORMANT - NAME and relationship to decedent<br><b>Litwiller-Simonsen F.H.</b>  |   |
| 20. METHOD OF DISPOSITION <input type="checkbox"/> Mausoleum <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)<br><b>Litwiller-Simonsen Crematory</b> |  | 21. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)<br><b>Ashland, OR</b>                               |   |
| 22. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH<br><i>[Signature]</i>   |  | 23. LICENSE NUMBER (If Licensee)<br><b>3360</b>  |   |
| 24. NAME, ADDRESS AND ZIP OF FACILITY<br><b>Litwiller - Simonsen Funeral Home</b><br><b>1211 Ashland St., Ashland, OR 97520</b>  |  | 25. DATE FILED (Month, Day, Year)<br><b>OCT 29 1991</b>  |   |
| 26. DID HOSPITAL REPRESENTATIVE MAKE REQUEST FOR ANATOMICAL GIFT CONSENT?<br><input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> N/A  |  | 27. WAS GIFT MADE?<br><input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> N/A     |   |
| TO BE COMPLETED BY CERTIFYING PHYSICIAN  |  |  |   |
| 28. TIME OF DEATH<br><b>10:30 AM</b>   |  | 29. WAS MEDICAL EXAMINER NOTIFIED?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                  |   |
| 30. To the best of my knowledge, death occurred at the time, date, place and due to the cause(s) and manner stated.<br>(Signature)<br><i>[Signature]</i>   |  |  |   |
| 31. DATE SIGNED (Month, Day, Year)<br><b>10-23-91</b>  |  |  |   |
| 32. NAME, TITLE, ADDRESS AND ZIP OF CERTIFIER/MEDICAL EXAMINER (Type or Print)<br><b>Michael Robinson M.D. 524 Manzanita Dr. Central Point, OR</b>   |  |  |   |
| 33. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)  |  |  |   |
| 34. 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) <b>CAUSE OF DEATH</b><br><b>CONSAULT WOUND TO THE HEAD</b><br><b>(Zacac Ribea)</b>  |  |  |   |
| PART II (b) <b>OTHER SIGNIFICANT CONDITIONS</b><br>Conditions contributing to death but not related to cause given in PART I.  |  |  |   |
| 35. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Suicide <input type="checkbox"/> Legal intervention <input type="checkbox"/> Homicide     |  |  |   |
| 36a. DATE OF INJURY (Month, Day, Year)<br><b>UNK</b>   |  | 36b. TIME OF INJURY<br><b>UNK</b>  |   |
| 36c. INJURY AT WORK?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 36d. DESCRIBE HOW INJURY OCCURRED<br><b>SHOT SELF IN HEAD</b>  |   |
| 36e. PLACE OF INJURY - At home, farm, street, factory, office, building etc. (Specify)<br><b>REST AREA</b>   |  | 36f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>Highway 66, 11 P. 16 Jackson County</b> |   |
| RESERVED FOR REGISTRARS USE<br><b>S750</b>   |  |  |   |

I CERTIFY THAT THIS IS A TRUE, FULL AND CORRECT COPY OF THE ORIGINAL CERTIFICATE ON FILE IN THE VITAL RECORDS UNIT OF THE OREGON STATE HEALTH DIVISION.

FEB 13 1992

DATE ISSUED

EDWARD J. JOHNSON II  
STATE REGISTRAR

STATE OF OREGON: COUNTY OF KLAMATH: ss.

Filed for record at request of Klamath County Title Co. the 6th day  
of April A.D., 19 92 at 1:32 o'clock P M., and duly recorded in Vol. M92  
of Deeds on Page 7180  
By Evelyn Biehn County Clerk  
By Pauline Muelendore

FEE \$10.00

92 APR 5 PM 1 32

RETURN: SHAPIRO & KREISMAN  
522 SW FIFTH, SUITE 825  
PORTLAND, OR 97204