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I.D. TAG NO.  
408OREGON DEPARTMENT OF HUMAN RESOURCES  
HEALTH DIVISION  
CENTER FOR HEALTH STATISTICS  
CERTIFICATE OF DEATHVol. m92 Page 22488  
136-

Local File Number

State File Number

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 1. DECEDENT'S NAME<br><b>Gretta H. SAY</b>  |  | 2. SEX<br><b>Female</b>  |  | 3. DATE OF DEATH (Month, Day, Year)<br><b>September 16, 1992</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>442-14-3078</b>   |  | 5a. AGE-Last Birthday (Years)<br><b>73</b>   |  | 5b. Under 1 Year<br>Mos. <b>1</b> Days <b>1</b> Hours <b>1</b> Mins. <b>1</b>  |  |
| 6. BIRTHPLACE (City and State or Foreign Country)<br><b>Quapaw, OK</b>  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>November 15, 1918</b>  |  |  |  |
| 8. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 9a. PLACE OF DEATH (Check only one)<br><input type="checkbox"/> HOSPITAL <input checked="" type="checkbox"/> Patient <input type="checkbox"/> EROutpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input 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)<br><b>Merle West Medical Center</b>  |  | 9c. CITY, TOWN, OR LOCATION OF DEATH<br><b>Klamath Falls</b>   |  | 9d. COUNTY OF DEATH<br><b>Klamath</b>  |  |
| 10a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.)<br><b>Potato Field Worker</b>  |  | 10b. KIND OF BUSINESS/INDUSTRY<br><b>Agriculture</b>   |  | 11. MARITAL STATUS - Married, Never Married, Widowed, Divorced (Specify)<br><b>Married</b>   |  |
| 12. SPOUSE (If Married, Widowed)<br><b>Orlo R. Say</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>3733 Bisbee Street</b>   |  |  |  |  |  |
| 13e. INSIDE CITY LIMITS?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 13f. ZIP CODE<br><b>97603</b>  |  | 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)<br><b>White</b>  |  | 16. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (14 or 15+)   |  |  |  |
| 17. FATHER - NAME first middle last<br><b>Chandler</b>  |  | 18. MOTHER - NAME first middle maiden<br><b>May Lacewell</b>   |  | 19. INFORMANT - NAME and relationship to deceased<br><b>Orlo R. Say Spouse</b>   |  |
| 20a. 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)            |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)<br><b>Klamath Memorial Park</b>  |  | 20c. LOCATION - City or Town, State<br><b>Klamath Falls, Oregon</b>  |  |
| 21a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH<br><i>James O. Rogers</i>   |  | 21b. LICENSE NUMBER (Of Licensee)<br><b>52-0297</b>  |  | 22. NAME, ADDRESS AND ZIP OF FACILITY<br><b>O'Hair's Funeral Chapel<br/>515 Pine ST. Klamath Falls, OR 97601</b>   |  |
| 23. DATE FILED (Month, Day, Year)<br><b>SEP 21 1992</b>   |  | 24. REGISTRAR'S SIGNATURE<br><i>Charles Robinson</i>   |  |  |  |
| 25. DID HOSPITAL REPRESENTATIVE MAKE REQUEST FOR ANATOMICAL GIFT CONSENT?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> N/A   |  | 26. WAS GIFT MADE?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> N/A   |  |  |  |
| TO BE COMPLETED BY CERTIFYING PHYSICIAN   |  |  | TO BE COMPLETED ONLY BY MEDICAL EXAMINER |  |  |
| 27. TIME OF DEATH<br><b>9:09 P M</b>  |  | 28. WAS MEDICAL EXAMINER NOTIFIED?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 31a. TIME OF DEATH<br><b>M</b>   |  |
| 29. To the best of my knowledge, death occurred at the time, date, place and due to the cause(s) and manner stated.<br>(Signature) <i>William B. Baker M.D.</i>   |  | 32. On the basis of examination and/or investigation, in my opinion death occurred at the time, date, place and due to the cause(s) and manner stated.<br>(Signature)  |  |  |  |
| 30. DATE SIGNED (Month, Day, Year)<br><b>9-18-92</b>  |  | 33. DATE SIGNED (Month, Day, Year) COUNTY  |  |  |  |
| 34. NAME, TITLE, ADDRESS AND ZIP OF CERTIFIER/MEDICAL EXAMINER (Type or Print)<br><b>William Baker M.D. 2600 Campus Drive Klamath Falls, Oregon 97601</b>   |  |  |  |  |  |
| 35. 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.   |  |  |  | Interval between onset and death   |  |
| PART I (a) <b>Acute Myocardial Infarction</b>   |  |  |  | <b>36 Hours</b>  |  |
| DUE TO, OR AS A CONSEQUENCE OF:   |  |  |  | Interval between onset and death   |  |
| (b)   |  |  |  | Interval between onset and death   |  |
| DUE TO, OR AS A CONSEQUENCE OF:   |  |  |  | Interval between onset and death   |  |
| PART II (c)   |  |  |  | Interval between onset and death   |  |
| OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not resulting in the underlying cause given in PART I.  |  |  |  | 37. Did tobacco use contribute to the death?<br><input type="checkbox"/> Yes <input type="checkbox"/> Probably <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown     |  |
| 38. AUTOPSY<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> N/A   |  |  |  | 39. If YES were findings considered in determining cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A                                |  |
| 40. MANNER OF DEATH<br><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"/> Legal Intervention |  | 41a. DATE OF INJURY (Month, Day, Year)   |  | 41b. TIME OF INJURY<br><b>M</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 41c. INJURY AT WORK?<br><input type="checkbox"/> Yes <input checked="" 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)   |  |  |  |
| RESERVED FOR REGISTRAR'S USE  |  |  |  |  |  |

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REGISTERED AT THE OFFICE OF THE KLAMATH COUNTY REGISTRAR.

SEP 21 1992

DATE ISSUED:

Charles Barcus  
CHARLENE BARCUS  
KLAMATH COUNTY, OREGON

45-2 607 791



STATE OF OREGON: COUNTY OF KLAMATH: ss.

Filed for record at request of Orlo R. Say the 28th day  
of Sept. A.D., 19 92 at 2:20 o'clock P M., and duly recorded in Vol. M92  
of Deeds on Page 22488

FEE \$10.00  
Return: Orlo Say  
3733 Bisbee, Klamath Falls, Or. 97603

Evelyn Biehn - County Clerk  
By Charles Barcus