

094329

I.D. TAG NO.

431

Local File Number

OREGON DEPARTMENT OF HUMAN RESOURCES

HEALTH DIVISION

CENTER FOR HEALTH STATISTICS

CERTIFICATE OF DEATH

136-

State File Number

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51842

DECEDENT

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FATHER

DISPOSITION

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8

9

REGISTRAR

CERTIFIER

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13

14

CONDITIONS

WHICH GAVE

RISE TO

IMMEDIATE

CAUSE

STATING THE

UNDERLYING

CAUSE LAST

CAUSE OF

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1. DECEDENT'S First NAME Elizabeth		Middle Agnes		Last MCCULLEY		2. SEX Female	3. DATE OF DEATH (Month, Day, Year) September 22, 1992
4. SOCIAL SECURITY NUMBER 540-44-2968		5a. AGE Last Birthday (Years) 87	5b. Under 1 Year Mos. Days	5c. Under 1 Day Hours Mins	6. BIRTHPLACE (City and State or Foreign Country) Wilder, Kansas		7. DATE OF BIRTH (Month, Day, Year) October 12, 1904
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 checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/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)							
9b. FACILITY NAME (If not institution, give street and number) Merle West Medical Center					9c. CITY, TOWN, OR LOCATION OF DEATH Klamath Falls		9d. COUNTY OF DEATH Klamath
10a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Homemaker		10b. KIND OF BUSINESS/INDUSTRY Own Home		11. MARITAL STATUS - Married, Never Married, Widowed, Divorced (Specify) Widowed		12. SPOUSE (If Married, Widowed) John B. McCulley	
13a. RESIDENCE - STATE Oregon		13b. COUNTY Klamath		13c. CITY, TOWN OR LOCATION Malin		13d. STREET AND NUMBER 29189 Hwy. 50 (P.O. Box 13)	
13e. INSIDE CITY LIMITS? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		13f. ZIP CODE 97634		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 (1-12) College (14 or 5+) 8		17. FATHER - Name first middle last Charles A. Maupin					
18. MOTHER - Name first middle maiden Ella Johnson		19. INFORMANT - Name and relationship to decedent Catherine Chamberlain Daughter					
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) Malin Community Cemetery		20c. LOCATION - City or Town, State Malin, Oregon			
21a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH <i>James A. Riggs</i>		21b. LICENSE NUMBER (Of license) 52-0297		22. NAME, ADDRESS AND ZIP OF FACILITY O'Hair's Funeral Chapel 515 Pine St. Klamath Falls, OR 97601			
23. DATE FILED (Month, Day, Year) SEP 24 1992		24. REGISTRAR'S SIGNATURE <i>Charla Robinson</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					
TO BE COMPLETED BY CERTIFYING PHYSICIAN							
27. TIME OF DEATH 10:47 A		28. WAS MEDICAL EXAMINER NOTIFIED? <input type="checkbox"/> Yes <input checked="" 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>Randall A. Machado</i> M.D.							
30. DATE SIGNED (Month, Day, Year) September 24, 1992							
31. NAME, TITLE, ADDRESS AND ZIP OF CERTIFYING MEDICAL EXAMINER (Type or Print) Randall A. Machado M.D. 1905 Main Street Klamath Falls, Oregon 97601							
32. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)							
TO BE COMPLETED ONLY BY MEDICAL EXAMINER							
31a. TIME OF DEATH M		31b. DATE PRONOUNCED DEAD (Month, Day, Year) M					
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. (Signature)							
33. DATE SIGNED (Month, Day, Year) COUNTY							
PART I 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) Sudden Cardiorespiratory Arrest of uncertain etiology		Interval between onset and death Seconds					
DUE TO, OR AS A CONSEQUENCE OF:							
(b)		Interval between onset and death					
DUE TO, OR AS A CONSEQUENCE OF:							
(c)		Interval between onset and death					
PART II OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not resulting in the underlying cause given in PART I. Right Lung Atelectasis, Congestive Heart Failure, Lung Tumors - Presumed Metastatic Colon Cancer Post-operative surgery for Arterial and Venous Thrombosis							
37. Did tobacco use contribute to the death? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input checked="" type="checkbox"/> No <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 type="checkbox"/> N/A			
40. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <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 M		41c. INJURY AT WORK? <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							

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

DATE ISSUED:

SEP 24 1992

Charlene Barcus
CHARLENE BARCUS
COUNTY REGISTRAR
KLAMATH COUNTY, OREGON

STATE OF OREGON: COUNTY OF KLAMATH: ss.

Filed for record at request of Catherine Chamberlain the 5th day
of Oct. A.D., 19 92 at 11:13 o'clock A M., and duly recorded in Vol. M92,
of Deeds on Page 23181.

Evelyn Biehn - County Clerk

By Charlene Barcus

FEE \$10.00

Return: Catherine Chamberlain

410 Trinity, Klamath Falls, Or. 97601