PRINT IN PERMANENT BLACK INK

F-8044
I.D. TAG NO.

18
Local File Number

56314

OREGON DEPARTMENT OF HUMAN RESOURCES
HEALTH DIVISION
CENTER FOR HEALTH STATISTICS
CERTIFICATE OF DEATH

136-
State File Number

DECEDENT

1. DECEDENT'S NAME First	Middle	Last	2. SEX	3. DATE OF DEATH (Month, Day, Year)
Carl	Leo	ERIKSEN	M	January 9, 1993

4. SOCIAL SECURITY NUMBER	5a. AGE Last Birthday (Years)	5b. Under 1 Year: Mos / Days	5c. Under 1 Day: Hours / Mins	6. BIRTHPLACE (City and State or Foreign Country)	7. DATE OF BIRTH (Month, Day, Year)
532-28-0591	62			Seattle, WA	May 7, 1930

8. WAS DECEDENT EVER IN U.S. ARMED FORCES? ☒ Yes ☐ No

9a. PLACE OF DEATH (Check only one): HOSPITAL ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Decedent's Home ☐ Other (Specify)

9b. FACILITY NAME (If not institution, give street and number)	9c. CITY, TOWN, OR LOCATION OF DEATH	9d. COUNTY OF DEATH
St. Charles Medical Center	Bend	Deschutes

10a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	10b. KIND OF BUSINESS/INDUSTRY	11. MARITAL STATUS - Married, Never Married, Widowed, Divorced (Specify)	12. SPOUSE (If Married, Widowed)
Lumber Grader	Timber	Married	Sherry

13a. RESIDENCE - STATE	13b. COUNTY	13c. CITY, TOWN OR LOCATION	13d. STREET AND NUMBER
Oregon	Klamath	Crescent	#1 Eriksen Hill

13e. INSIDE CITY LIMITS?	13f. ZIP CODE	14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.)	15. RACE American Indian, Black, White, etc. (Specify)	16. DECEDENT'S EDUCATION (Specify only highest grade completed)	
				Elementary/Secondary (0-12)	College (1-4 or 5+)
☐ Yes ☒ No	97733	☒ No ☐ Yes Specify	White	12	

PARENTS

17. FATHER - NAME first middle last	18. MOTHER - NAME first middle maiden	19. INFORMANT - NAME and relationship to deceased
Leo Carl Eriksen	Esther Harle	Sherry Eriksen, Wife

DISPOSITION

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	20c. LOCATION - City or Town, State
☐ Burial ☐ Cremation ☐ Removal from State ☒ Donation ☐ Other (Specify)	University of Oregon Health Sciences Center	Portland, OR

REGISTRAR

21a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH	21b. LICENSE NUMBER (Of Licensee)	22. NAME, ADDRESS AND ZIP OF FACILITY
Ron L Reynolds	0087	Niswonger-Reynolds, Inc. 105 N.W. Irving Bend, OR 97701

23. DATE FILED (Month, Day, Year)	24. REGISTRAR'S SIGNATURE
January 11 1993	Jacqueline Mathis, Dep

25. DID HOSPITAL REPRESENTATIVE MAKE REQUEST FOR ANATOMICAL GIFT CONSENT? ☒ YES ☐ NO ☐ N/A

26. WAS GIFT MADE? ☒ YES ☐ NO ☐ N/A

CERTIFIER

TO BE COMPLETED BY CERTIFYING PHYSICIAN

27. TIME OF DEATH	28. WAS MEDICAL EXAMINER NOTIFIED?
7:35 P. M	☐ Yes ☒ 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) MD

30. DATE SIGNED (Month, Day, Year) 1/11/93

TO BE COMPLETED ONLY BY MEDICAL EXAMINER

31a. TIME OF DEATH	31b. DATE PRONOUNCED DEAD (Month, Day, Year, Hour)
M	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

34. NAME, TITLE, ADDRESS AND ZIP OF CERTIFIER/MEDICAL EXAMINER (Type or Print): Stephen Kunfeld MD 1501 N.E. Medical Center Dr. Bend, OR 97701

35. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)

CAUSE OF DEATH

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

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)	Pancreatic Cancer	4 mo
(b) DUE TO, OR AS A CONSEQUENCE OF:		
(c) DUE TO, OR AS A CONSEQUENCE OF:		

PART II 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?	38. AUTOPSY	39. If YES were findings considered in determining cause of death?
☐ Yes ☐ Probably ☒ No ☐ Unknown	☐ Yes ☒ No	☐ Yes ☐ No ☐ N/A

40. MANNER OF DEATH	41a. DATE OF INJURY (Month, Day, Year)	41b. TIME OF INJURY	41c. INJURY AT WORK?	41d. DESCRIBE HOW INJURY OCCURRED
☐ Natural ☐ Pending Investigation ☐ Accident ☐ Undetermined Manner ☐ Suicide ☐ Legal Intervention ☐ Homicide		M	☐ Yes ☐ No	
	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

ORIGINAL-VITAL STATISTICS COPY

45-2 Rev 4-92

STATE OF OREGON, COUNTY OF DESCHUTES

I HEREBY CERTIFY THAT THE FOREGOING COPY HAS BEEN COMPARED BY ME WITH THE ORIGINAL DOCUMENT AND IS A TRUE, FULL AND CORRECT COPY OF THE ORIGINAL CERTIFICATE AS THE SAME APPEARS ON FILE IN THE VITAL RECORDS UNIT OF THE DESCHUTES COUNTY HEALTH DEPARTMENT AND IN MY OFFICIAL CARE AND CUSTODY.

NOT VALID WITHOUT RAISED SEAL OF DESCHUTES COUNTY HEALTH DEPARTMENT

Jacqueline Mathis, Deputy Registrar
JACQUELINE MATHIS, DEPUTY REGISTRAR

DATE January 11, 1993

Please return to:
Niswonger-Reynolds, Inc
P.O. Box 229
Bend, OR 97709

STATE OF OREGON: COUNTY OF KLAMATH: ss.

Filed for record at request of _____ the 13th day of Jan. A.D., 19 93 at 9:21 o'clock A M., and duly recorded in Vol. M93, of Deeds on Page 904.

Evelyn Biehn County Clerk
By Doreen Mullendore

FEE $10.00