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I.D. TAG NO.
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OREGON DEPARTMENT OF HUMAN RESOURCES
HEALTH DIVISION
CENTER FOR HEALTH STATISTICS
CERTIFICATE OF DEATH

136-

Local File Number

State File Number

DECEDENT

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PARENTS

DISPOSITION

7

8

9

REGISTRAR

CERTIFIER

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

CAUSE OF
DEATH

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1. DECEDENT'S NAME First: Effie Middle: Last: FOLLOCK			2. SEX Female	3. DATE OF DEATH (Month, Day, Year) February 2, 1993
4. SOCIAL SECURITY NUMBER 541-24-8031		5a. AGE-Last Birthday (Years) 74	5b. Under 1 Year Mos Days Hours Mins	6. BIRTHPLACE (City and State or Foreign) Klamath Falls, OR
7. DATE OF BIRTH (Month, Day, Year) October 15, 1918		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 type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> DCA <input type="checkbox"/> OTHER <input checked="" 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) Plum Ridge Care 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) Married
12. SPOUSE (If Married, Widowed) Leon Follick		13a. RESIDENCE - STATE Oregon		
13b. COUNTY Klamath		13c. CITY, TOWN OR LOCATION Klamath Falls		
13d. STREET AND NUMBER 1531 Avalon Street		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		
15. RACE American Indian, Black, White, etc. (Specify) White		16. DECEDENT'S EDUCATION (Specify only highest grade completed) 12		
17. FATHER - NAME first middle last Elbert Harve Johnson		18. MOTHER - NAME first middle maiden Alice - Hibberts		19. INFORMANT - NAME and relationship to decedent Leon Follick - Spouse
20a. 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)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) Eternal Hills Memorial Gardens		20c. LOCATION - City or Town, State Klamath Falls, Oregon
21a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH <i>[Signature]</i>		21b. LICENSE NUMBER (or License) 93-49-1363		22. NAME, ADDRESS AND ZIP OF FACILITY Eternal Hills Funeral Home 4711 Highway 39, Klamath Falls, OR 97603
23. DATE FILED (Month, Day, Year) FEB 03 1993		24. REGISTRAR'S SIGNATURE <i>[Signature]</i>		
25. DID HOSPITAL REPRESENTATIVE MAKE REQUEST FOR ANATOMICAL GIFT CONSENT? <input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> N/A				
26. WAS GIFT MADE? <input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> N/A				
TO BE COMPLETED BY CERTIFYING PHYSICIAN				
27. TIME OF DEATH 6:05 A.M.		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>[Signature]</i> M.D.				
30. DATE SIGNED (Month, Day, Year) February 2, 1993				
31. NAME, TITLE, ADDRESS AND ZIP OF CERTIFYING MEDICAL EXAMINER (Type or Print) Blake Berven M.D. 2616 Clover Street, 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.				
PART I (a) Cardogenic shock DUE TO, OR AS A CONSEQUENCE OF:		Interval between onset and death 5 minutes		
(b) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF:		Interval between onset and death 5 minutes		
(c) ASHD		Interval between onset and death unknown		
PART II OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not resulting in the underlying cause given in PART I. Metastatic breast carcinoma. Idiopathic pulmonary fibrosis.				
37. Did tobacco use contribute to the death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> Probably <input 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 checked="" 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		41c. INJURY AT WORK? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
41d. PLACE OF INJURY - At home, farm, street, factory, office building etc. (Specify)		41e. LOCATION (Street and Number or Rural Route Number, City or Town, State)		

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

DATE ISSUED: FEB 04 1993

Charles Barcus
CHARLENE BARCUS
COUNTY REGISTRAR
KLAMATH COUNTY, OREGON

STATE OF OREGON: COUNTY OF KLAMATH: ss.

Filed for record at request of _____ the 8th day of Feb., A.D., 19 93 at 2:09 o'clock P.M., and duly recorded in Vol. M93 of Deeds on Page 2832.

FEE \$10.00
Return: Leon Follick
1531 Avalon, Klamath Falls, Or. 97603

Evelyn Biehn - County Clerk
By *[Signature]*