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I.D. TAG NO.

93-25664

OREGON DEPARTMENT OF HUMAN RESOURCES

HEALTH DIVISION

CENTER FOR HEALTH STATISTICS

CERTIFICATE OF DEATH

Vol. m93 Page 19001

306 - 2854

65558 417  
Local File Number

State File Number

|                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                                                   |                                                      |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|
| 1. DECEDENT'S NAME<br>First: Francis, Middle: Lee, Last: EDWARDS                                                                                                                                                                                                              |  | 2. SEX<br>M                                                                                                                                                                                                                                                                                                                                       | 3. DATE OF DEATH (Month, Day, Year)<br>July 24, 1993 |
| 4. SOCIAL SECURITY NUMBER<br>570-30-7378                                                                                                                                                                                                                                      |  | 5a. AGE-Last Birthday (Years)<br>64                                                                                                                                                                                                                                                                                                               | 5b. Under 1 Year<br>Mos. Days Hours Mins.            |
| 6. BIRTHPLACE (City and State or Foreign Country)<br>Coville, Kansas                                                                                                                                                                                                          |  | 7. DATE OF BIRTH (Month, Day, Year)<br>July 25, 1928                                                                                                                                                                                                                                                                                              |                                                      |
| 8. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                             |  | 9a. PLACE OF DEATH (Check only one)<br><input type="checkbox"/> HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" 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>1732 N.E. Pinewood                                                                                                                                                                                          |  | 9c. CITY, TOWN, OR LOCATION OF DEATH<br>Bend                                                                                                                                                                                                                                                                                                      |                                                      |
| 10a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)<br>Truck Driver                                                                                                                                                     |  | 10b. KIND OF BUSINESS/INDUSTRY<br>Trucking                                                                                                                                                                                                                                                                                                        |                                                      |
| 11. MARITAL STATUS (Specify if Married, Widowed, Divorced)<br>Married                                                                                                                                                                                                         |  | 12. SPOUSE (if Married, Widowed)<br>Evelyn                                                                                                                                                                                                                                                                                                        |                                                      |
| 13a. RESIDENCE - STATE<br>Oregon                                                                                                                                                                                                                                              |  | 13b. COUNTY<br>Deschutes                                                                                                                                                                                                                                                                                                                          |                                                      |
| 13c. CITY, TOWN OR LOCATION<br>Bend                                                                                                                                                                                                                                           |  | 13d. STREET AND NUMBER<br>1732 N.E. Pinewood                                                                                                                                                                                                                                                                                                      |                                                      |
| 14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input checked="" type="checkbox"/> No <input type="checkbox"/> Yes                                                                                          |  | 15. RACE American Indian, Black, White, etc. (Specify)<br>White                                                                                                                                                                                                                                                                                   |                                                      |
| 16. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (6-12) College (14 or 5+)<br>12                                                                                                                                                       |  | 17. FATHER - NAME first middle last<br>Charles T. Edwards                                                                                                                                                                                                                                                                                         |                                                      |
| 18. MOTHER - NAME first middle maiden<br>Emma Baskins                                                                                                                                                                                                                         |  | 19. INFORMANT NAME and relationship to decedent<br>Evelyn Edwards, Wife                                                                                                                                                                                                                                                                           |                                                      |
| 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>Central Oregon Cremation Assn.                                                                                                                                                                                                                                         |                                                      |
| 20c. LOCATION - City or Town, State<br>Bend, Oregon                                                                                                                                                                                                                           |  | 21a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH<br><i>Thomas C. W.</i>                                                                                                                                                                                                                                                        |                                                      |
| 21b. LICENSE NUMBER (Of Licensee)<br>3110                                                                                                                                                                                                                                     |  | 22. NAME, ADDRESS AND ZIP OF FACILITY<br>Niswonger-Reynolds, Inc.<br>105 N.W. Irving Bend, OR 97701                                                                                                                                                                                                                                               |                                                      |
| 23. DATE FILED (Month, Day, Year)<br>July 26, 1993                                                                                                                                                                                                                            |  | 24. REGISTRAR'S SIGNATURE<br><i>Jacqueline Mathis, Dep</i>                                                                                                                                                                                                                                                                                        |                                                      |
| 25. DID HOSPITAL REPRESENTATIVE MAKE REQUEST FOR ANATOMICAL GIFT CONSENT?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input checked="" 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                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                                                   |                                                      |
| 27. TIME OF DEATH<br>4:15 P. M.                                                                                                                                                                                                                                               |  | 28. WAS MEDICAL EXAMINER NOTIFIED?<br><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 causes and manner stated.<br>(Signature)<br><i>Richard H. Woods, M.D.</i>                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                   |                                                      |
| 30. DATE SIGNED (Month, Day, Year)<br>July 24, 1993                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                                                   |                                                      |
| 31. NAME, TITLE, ADDRESS AND ZIP OF CERTIFIER/MEDICAL EXAMINER (Type or Print)<br>Richard H. Woods, M.D. 1501 N.E. Medical Center Dr. Bend, OR 97701                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                                                   |                                                      |
| 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) <i>Basal differentiated carcinoma, ? origin</i>                                                                                                                                                                                                                    |  | Interval between onset and death<br>4 mos.                                                                                                                                                                                                                                                                                                        |                                                      |
| (b) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                                                                                                           |  | Interval between onset and death                                                                                                                                                                                                                                                                                                                  |                                                      |
| (c) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                                                                                                           |  | 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.<br><i>Radialy thyroid carcinoma</i>                                                                                                        |  |                                                                                                                                                                                                                                                                                                                                                   |                                                      |
| 34. 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 |  | 35. 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                                                                                                                                                            |                                                      |
| 36. AUTOPT? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                               |  | 37. If YES, were findings considered in determining cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> N/A                                                                                                                                                                           |                                                      |
| 40. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                         |  | 41a. TIME OF INJURY                                                                                                                                                                                                                                                                                                                               |                                                      |
| 41b. PLACE OF INJURY - At home, farm, street, factory, office building etc. (Specify)                                                                                                                                                                                         |  | 41c. INJURY AT WORK?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                       |                                                      |
| 41d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                             |  | 41e. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                      |                                                      |

ORIGINAL-VITAL STATISTICS COPY

45-2 Rev 11-92

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

DATE

July 26, 1993

Please return to Niswonger-Reynolds Inc.  
PO Box 229 Bend, OR 97709

STATE OF OREGON, ss.  
County of Klamath

Filed for record at request of:

Niswonger-Reynolds Inc.

on this 2nd day of Aug. A.D., 19 93  
at 3:18 o'clock p M. and duly recorded  
in Vol. M93 of Deeds Page 19001

Evelyn Biehn County Clerk

By *Pauline Muelendorp* Deputy.

Fee, \$10.00

STATE OF OREGON ) ss.  
COUNTY OF DESCHUTES )

I, MARY SUE PENHOLLOW, COUNTY CLERK AND  
RECORDER OF CONVEYANCES, IN AND FOR SAID  
COUNTY, DO HEREBY CERTIFY THAT THE WITHIN  
INSTRUMENT WAS RECORDED THIS DAY:

93 JUL 28 PM 3:52  
MARY SUE PENHOLLOW  
COUNTY CLERK

DEPUTY  
NO. 93-25664 FEE 13.00  
DESCHUTES COUNTY OFFICIAL RECORDS