

66034

08-10-93A11:39 RCVD

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ID TAG NO.

Local File Number

STATE OF OREGON  
OREGON STATE HEALTH DIVISION  
DEPARTMENT OF HUMAN SERVICES  
Vital Records Unit  
CERTIFICATE OF DEATH

State File Number

TYPE  
OR PRINT  
IN  
PERMANENT  
BLACK  
INK  
FOR  
INSTRUCTIONS  
SEE  
HANDBOOKDECEDENT  
IF DEATH  
OCCURRED IN  
INSTITUTION,  
SEE HANDBOOK  
REGARDING  
COMPLETION OF  
RESIDENCE ITEMS

DISPOSITION

CERTIFIER

CONDITIONS  
IF ANY  
WHICH GAVE  
RISE TO  
IMMEDIATE  
CAUSE  
STATING THE  
UNDERLYING  
CAUSE LASTCAUSE OF  
DEATH

DECEASED - NAME		First		Middle		Last		DATE OF DEATH (month, day, year)	
1		Georgianne		Gifford		ATWATER		2 January 3, 1987	
RACE White, Black, American Indian, etc. (specify)		SEX		AGE - Last birthday (years)		Under 1 year		DATE OF BIRTH (month, day, year)	
3 White		4 Female		5a 39		5b mos days		6 May 24, 1947	
CITY, TOWN OR LOCATION OF DEATH		HOSPITAL OR OTHER INSTITUTION - NAME (if not in either, give street and number)		IF HOSP. OR INST. indicate I/OA OP, Emer. Rm., Inpatient (specify)		7c Inpatient		7d Deschutes	
7a Bend		7b St. Charles Medical Center							
STATE OF BIRTH (if not in U.S.A., name country)		CITIZEN OF WHAT COUNTRY		MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		SPOUSE (IF MARRIED, WIDOWED)		WAS DECEDENT EVER IN U.S. ARMED FORCES? (specify yes or no)	
8 Louisiana		9 USA		10 Married		11 Gerald		12 no	
SOCIAL SECURITY NUMBER		USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		KIND OF BUSINESS OR INDUSTRY					
13 526 84 1943		14a Teacher		14b Education					
RESIDENCE - STATE		COUNTY		CITY, TOWN OR LOCATION		STREET AND NUMBER OR R.F.D.		ZIP	
15a Oregon		15b Deschutes		15c Bend		15d 62737 Montara Drive		15e 97701	
FATHER - NAME first middle last		MOTHER - first middle last (Maiden Name)		INFORMANT - NAME and relationship to decedent					
16a Jess H. Gifford		16b Pauline M. Throck		17 Gerald Atwater		18 Husband			
BURIAL, CREMATION, REMOVAL, MAUS. (specify)		CEMETERY OR CREMATORY - NAME		LOCATION		City or town		State	
19a Cremation		19b Central Oregon Cremation Assn.		19c Bend		Oregon			
FUNERAL SERVICE LICENSEE or person acting as such		NAME AND ADDRESS OF FACILITY							
20a David L. Gabel		20b Niswonger-Reynolds, Inc. 105 N.W. Irving Bend, OR 97701							
To this best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated.		DATE SIGNED (Mo., Day, Year)		HOUR OF DEATH					
21a (Signature) David L. Gabel		21b 1/5/87		21c 7:41 P.		M			
NAME, TITLE AND ADDRESS OF CERTIFIER (Type or Print)		ZIP							
21d Robert F. Boone M.D.		1501 N.E. Medical Center Drive		Bend, OR 97701					
NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)									
DATE RECEIVED BY REGISTRAR (Mo., Day, Year)		REGISTRAR							
22a January 5, 1987		22b (Signature) Jacqueline Mathis, Rep.							
IMMEDIATE CAUSE		INTERVAL BETWEEN ONSET AND DEATH							
(a) Renal failure		4 days							
(b) Due to, or as a consequence of: Nephrotic syndrome in liver, spleen + bones		3 months							
(c) Due to, or as a consequence of: Dissecting aortic aneurysm		4 days							
OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not related to cause given in PART I (a)		AUTOPSY (Specify Yes or No)		WAS MEDICAL EXAMINER NOTIFIED (Specify Yes or No)					
23		24 yes		25 No					
ACCIDENT (Specify Yes or No)		DATE OF INJURY (Mo., Day, Year)		HOUR OF INJURY		DESCRIBE HOW INJURY OCCURRED			
26a No		26b		26c		26d			
INJURY AT WORK (Specify Yes or No)		PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)		LOCATION		STREET OR R.F.D. NO		CITY OR TOWN STATE	
26e No		26f		26g					
DID HOSPITAL REPRESENTATIVE MAKE REQUEST FOR ANATOMICAL GIFT CONSENT?		WAS GIFT MADE?							
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> N/A <input type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> N/A <input type="checkbox"/>							
RESERVED FOR REGISTRAR'S USE									

ORIGINAL-VITAL STATISTICS COPY

45-2 Prev. 6-86

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

January 14, 1987  
DATE

STATE OF OREGON: COUNTY OF KLAMATH: ss.

Filed for record at request of Aspen Title Co the 10th day  
of Aug. A.D., 19 93 at 11:39 o'clock A.M., and duly recorded in Vol. M93  
of Deeds on Page 19822Evelyn Biehn - County Clerk  
By Pauline Mathis

FEE \$10.00

Return: Aspen Title Co