

CERTIFICATION OF VITAL RECORD

ASPEN#03040696

RETURN TO:
Joe Thomas
534 Pacific Terrace, Klamath Falls, OR 97601

OREGON HEALTH DIVISION
CENTER FOR HEALTH STATISTICS

TYPE OR PRINT IN PERMANENT BLACK INK

068279
115
Local File Number

OREGON DEPARTMENT OF HUMAN RESOURCES
HEALTH DIVISION
Vital Records Unit
CERTIFICATE OF DEATH

91-006784-7
State File Number

1. DECEASED'S NAME: **Marcea Elaine THOMAS**

2. SEX: **F**

3. DATE OF BIRTH (Month, Day, Year): **April 8, 1931**

4. SOCIAL SECURITY NUMBER: **540/20/4711**

5. AGE: **65**

6. PLACE OF BIRTH (City and State or Foreign Country): **Sussexville, Ca.**

7. DATE OF DEATH (Month, Day, Year): **June 23, 1993**

8. PLACE OF DEATH (Specify only one): **Home**

9. WAS DECEASED EVER IN U.S. ARMED FORCES? **No**

10. FACILITY NAME (If not resident, give street address of residence): **Merle West Medical Center**

11. CITY, TOWN, OR LOCATION OF DEATH: **Klamath Falls**

12. COUNTY OF DEATH: **Klamath**

13. DECEASED'S USUAL OCCUPATION (One kind of work done during most of working life): **Homemaker**

14. KIND OF BUSINESS/INDUSTRY: **Own Home**

15. MARITAL STATUS: **Married**

16. NAME OF SPOUSE: **Joe Don**

17. RESIDENCE - STATE: **Oregon**

18. COUNTY: **Klamath**

19. CITY, TOWN, OR LOCATION: **Klamath Falls**

20. STREET ADDRESS: **534 Pacific Terrace**

21. RACE: **White**

22. DECEASED'S EDUCATION (Specify only highest grade completed): **12**

23. FATHER'S NAME: **Grant Roy Dixon**

24. MOTHER'S NAME: **Blanche Riddle**

25. DECEASED'S MARRIAGE (Specify date of birth, date of marriage, date of death, date of remarriage, etc.): **Joe Thomas / Husband**

26. METHOD OF DISPOSITION: **Memorial Gardens**

27. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): **Klamath Falls, Oregon**

28. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH: **James R. Land**

29. LICENSE NUMBER (If Licensee): **3409**

30. NAME, ADDRESS AND ZIP OF FACILITY: **Ward's Klamath Funeral Home, 1945 Main Street, Klamath Falls, Ore. / 97601**

31. DATE FILED (Month, Day, Year): **APR 9 1991**

32. DID HOSPITAL REPRESENTATIVE MAKE REQUEST FOR ANATOMICAL GIFT CONSENT? **No**

33. THIS GIFT MADE? **No**

34. TIME OF DEATH: **0809**

35. WAS MEDICAL EXAMINER NOTIFIED? **No**

36. SIGNATURE OF MEDICAL EXAMINER: **Bernard Hales, MD**

37. DATE SIGNED (Month, Day, Year): **4/8/91**

38. NAME, TITLE, ADDRESS AND ZIP OF CERTIFYING MEDICAL EXAMINER (Type or Print): **Glenn G. Gailis, MD / 1905 Main Street / Klamath Falls, Oregon / 97601**

39. NAME OF ATTENDING PHYSICIAN (If other than certifier (Type or Print):

40. IMMEDIATE CAUSE (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), and (c). Do not enter details of dying, e.g., Cardiac or Respiratory Arrest): **ARRHYTHMIA - ASYSTOLE**

41. CAUSE TO, OR AS A CONSEQUENCE OF:

42. INTERMEDIATE CAUSE: **ASTERO SEIZANTIC HEART DISEASE**

43. OTHER SIGNIFICANT CONDITIONS: **STOPPING**

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