CERTIFICATION OF VITAL RECORD

97003

03-28-95A09:46 RCVD

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

Vol. M95 Page 7233

125888 I.D. TAG NO.

35 Local File Number

136- State File Number

1. DECEDENT'S NAME First	Middle	Last	2. SEX	3. DATE OF DEATH (Month, Day, Year)
John	Joseph	SCHIFANO	M	January 16, 1995

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)
554-03-9585	78			San Jose, CA.	August 10, 1916

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): St. Charles Medical Center

9c. CITY, TOWN, OR LOCATION OF DEATH: Bend

9d. COUNTY OF DEATH: 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)
Maintanance	School District	Married	Mary Schifano

13a. RESIDENCE - STATE	13b. COUNTY	13c. CITY, TOWN OR LOCATION	13d. STREET AND NUMBER
Oregon	Deschutes	Bend	51586 Ash Road

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.) ☒ No ☐ Yes Specify:	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	97739		White	6	

17. FATHER - NAME first middle last	18. MOTHER - NAME first middle maiden	19. INFORMANT - NAME and relationship to deceased
Peter Schifano	Antoinette Lagatutta	Mary Schifano - Wife

20a. METHOD OF DISPOSITION ☐ Mausoleum ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	20c. LOCATION - City or Town, State
	LaPine Community Cemetery	LaPine, Oregon

21a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH	21b. LICENSE NUMBER (Of Licensee)	22. NAME, ADDRESS AND ZIP OF FACILITY
Ronald R. Phillips	3500	Central Pines Funeral Home P.O. Box 1530 LaPine, Oregon 97739

23. DATE FILED (Month, Day, Year): January 18, 1995

24. REGISTRAR'S SIGNATURE: Nita Y. St. John, Dep

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

26. WAS GIFT MADE? ☐ YES ☐ NO ☒ N/A

TO BE COMPLETED BY CERTIFYING PHYSICIAN

27. TIME OF DEATH: 12:05 P. M

28. WAS MEDICAL EXAMINER NOTIFIED? ☐ 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) Robert V. Pinnick

30. DATE SIGNED (Month, Day, Year): 1/18/95

31. NAME, TITLE, ADDRESS AND ZIP OF CERTIFIER/MEDICAL EXAMINER (Type or Print): Robert Pinnick MD 1501 NE Med. Ctr. Drive, Bend OR 97701

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

TO BE COMPLETED ONLY BY MEDICAL EXAMINER

31a. TIME OF DEATH M

31b. DATE PRONOUNCED DEAD (Month, Day, Year, Hour) 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

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

CAUSE OF DEATH

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.

PART I
(a) Cerebral Thrombosis — Interval between onset and death: 1 week
DUE TO, OR AS A CONSEQUENCE OF:
(b) Atherosclerotic Vascular Disease — Interval between onset and death: 20 years
DUE TO, OR AS A CONSEQUENCE OF:
(c) — 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.
Chronic Renal Failure Atherosclerotic

37. Did tobacco use contribute to the death? ☒ Yes ☐ Probably ☐ No ☐ Unknown	38. AUTOPSY ☐ Yes ☒ No	39. If YES were findings considered in determining cause of death? ☐ Yes ☐ No ☐ N/A

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

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

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

DATE ISSUED: January 18, 1995

FLORENCE ABEND-TORRIGINO
COUNTY REGISTRAR
DESCHUTES COUNTY, OREGON

STATE OF OREGON: COUNTY OF KLAMATH : ss.

Filed for record at request of Mary Schifano of March A.D., 19 95 at 9:46 o'clock A M., and duly recorded in Vol. M95 of Deeds on Page 7233.

FEE $10.00

RETURN: Mary Schifano
P.O. Box 2053
LaPine Or 97739

Bernetha G. Letsch, County Clerk
By Lynette Mistag