

Local File Number

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

State File Number

Local File Number		Middle		Last		2 SEX		3 DATE OF DEATH (Month, Day, Year)	
1. DECEDENT'S NAME Lillie Irene YUNCK		First		Last		Female		June 28, 1995	
4. SOCIAL SECURITY NUMBER 543-05-8394		5a. AGE/Last Birthday (Years) 81		5b. Under 1 Year Mos. Days Hours Mins		6. BIRTHPLACE (City and State or Foreign Country) Helena, Montana		7. DATE OF BIRTH (Month, Day, Year) June 5, 1914	
8. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		9. HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DCA <input type="checkbox"/> OTHER		10. N. PLACE OF DEATH (Check only one) <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) Merle West Medical 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) William F. Yunk			
13a. RESIDENCE - STATE Oregon		13b. COUNTY Klamath		13c. CITY, TOWN OR LOCATION Klamath Falls		13d. STREET AND NUMBER 5080 Bryant Avenue			
13e. INSIDE CITY LIMITS? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		13f. ZIP CODE 97603		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 Specify:		15. RACE American Indian, Black, White, etc. (Specify) White		16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (14 or 5+) 12	
17. FATHER - NAME first middle last Peter Pearson		18. MOTHER - NAME first middle maiden Mable Hickman		19. INFORMANT - NAME and relationship to deceased William F. Yunk Spouse					
20a. METHOD OF DISPOSITION <input type="checkbox"/> Mausoleum <input 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 (Of Licensee) CO-3572		22. NAME, ADDRESS AND ZIP OF FACILITY O'Hair's Funeral Chaple 515 Pine ST. Klamath Falls, OR 97601		24. REGISTRAR'S SIGNATURE <i>[Signature]</i>		26. WAS GIFT MADE? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> N/A	
23. DATE FILED (Month, Day, Year) JUN 30 1995									
25. DID HOSPITAL REPRESENTATIVE MAKE REQUEST FOR ANATOMICAL GIFT CONSENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> N/A									
TO BE COMPLETED BY CERTIFYING PHYSICIAN									
27. TIME OF DEATH 2:30 P		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>		30. DATE SIGNED (Month, Day, Year) 6/29/95		31. NAME, TITLE, ADDRESS AND ZIP OF CERTIFIER/MEDICAL EXAMINER (Type or Print) Craig Merhoff M.D. 2850 Daggett Street Klamath Falls, Oregon 97601		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) <i>[Signature]</i>		33. DATE SIGNED (Month, Day, Year) COUNTY	
34. NAME, TITLE, ADDRESS AND ZIP OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)									
35. IMMEDIATE CAUSE (ENTER ONLY ONE CAUSE PER LINE FOR (b) AND (c)) Do not enter mode of dying, e.g. Cardiac or Respiratory Arrest. PART I (a) Melanotic Ovarian Cancer		Interval between onset and death hours							
(b) DUE TO, OR AS A CONSEQUENCE OF:									
(c) DUE TO, OR AS A CONSEQUENCE OF:									
PART II OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not resulting in the underlying cause given in PART I.		37. Did tobacco use contribute to the death? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		38. AUTOPSY <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		39. If YES were findings consistent in determining cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input 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 Manner <input type="checkbox"/> Suicide <input type="checkbox"/> Legal Intervention <input type="checkbox"/> Homicide		41a. DATE OF INJURY (Month, Day, Year)		41b. TIME OF INJURY M		41c. INJURY AT WORK? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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)	
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DATE ISSUED:

JUN 30 1995

JANET BAILEY GOBER
COUNTY REGISTRAR
KLAMATH COUNTY, OREGON

MULTNOMAH COUNTY DEPARTMENT OF HEALTH
OREGON
NOV 11 82

STATE OF OREGON: COUNTY OF KLAMATH: SS.

Filed for record at request of William F. Yuncck the 7th day
of July A.D., 19 95 at 11:24 o'clock A. M., and duly recorded in Vol. M95
of Deeds on Page 17605

Bernetha G. Letsch,

County Clerk

FEE \$10.00

By