NT 35839-HF

OREGON HEALTH DIVISION
CENTER FOR HEALTH STATISTICS

3590

Vol. 1195 Page 19862

NT IK 188593 I.D. TAG NO.

01421 Local File Number

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

95-005765 State File Number

07-31-95A10:44 RCVD

1. DECEDENT'S NAME: First: Dolly	Middle: Wetmore	Last: CHAFFEE	2. SEX: Female
3. DATE OF DEATH (Month, Day, Year): March 16, 1995			
4. SOCIAL SECURITY NUMBER: 544 10 7852	5a. AGE-Last Birthday (Years): 85	5b. Under 1 Year: Mos. / Days	5c. Under 1 Day: Hours / Mins.
6. BIRTHPLACE (City and State or Foreign Country): Allentown, Iowa	7. DATE OF BIRTH (Month, Day, Year): January 7, 1910		
8. WAS DECEDENT EVER IN U.S. ARMED FORCES? ☐ Yes ☒ No	8a. 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): Portland Adventist Convalescent Center	9c. CITY, TOWN, OR LOCATION OF DEATH: Portland	9d. COUNTY OF DEATH: Multnomah	
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): Widowed	12. SPOUSE (If Married, Widowed): Charles
13a. RESIDENCE - STATE: Oregon	13b. COUNTY: Multnomah	13c. CITY, TOWN OR LOCATION: Portland	13d. STREET AND NUMBER: 5929 SE 80th
13e. INSIDE CITY LIMITS? ☒ Yes ☐ No	13f. ZIP CODE: 97206	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): White
16. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):			
17. FATHER - NAME first middle last: James O. Wetmore	18. MOTHER - NAME first middle maiden: Nora Hurd	19. INFORMANT - NAME and relationship to deceased: Darryl Chaffee - Son	
20a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ 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: [signature]	21b. LICENSE NUMBER (Of Licensee): 3155	22. NAME, ADDRESS AND ZIP OF FACILITY: Caldwell's Colonial Chapel, 20 NE 14th Ave., Portland, OR 97232	
23. DATE FILED (Month, Day, Year): MAR 21 1995	24. REGISTRAR'S SIGNATURE: [signature]		
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: 3:00 pM	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): [signature]	
30. DATE SIGNED (Month, Day, Year): 3/17/95	

TO BE COMPLETED ONLY BY MEDICAL EXAMINER

31a. TIME OF DEATH: M	31b. DATE PRONOUNCED DEAD (Month, Day, Year, Hour)
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

34. NAME, TITLE, ADDRESS AND ZIP OF CERTIFIER/MEDICAL EXAMINER (Type or Print): Thomas H. Hickerson, MD 19850 SE Hwy. 212 Clackamas, OR 97015

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

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.

		Interval between onset and death
PART I (a)	Pneumonia	3 days
DUE TO, OR AS A CONSEQUENCE OF: (b)		
DUE TO, OR AS A CONSEQUENCE OF: (c)		

PART II OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not resulting in the underlying cause given in PART I: HTN, Renal Failure, Back pain

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

UPON Recording Return to Duane A Chaffee 6129 SE Ranson ST. PORTLAND OR 97206

I CERTIFY THAT THIS IS A TRUE, FULL AND CORRECT COPY OF THE ORIGINAL CERTIFICATE OR THE VITAL RECORD FACTS ON FILE IN THE VITAL RECORDS UNIT OF THE OREGON HEALTH DIVISION.

DATE ISSUED JUL 26 1995

[signature]
EDWARD J. JOHNSON II
STATE REGISTRAR

STATE OF OREGON: COUNTY OF KLAMATH : ss.

Filed for record at request of Mountain Title Co the 31st day of July A.D., 19 95 at 10:44 o'clock A M., and duly recorded in Vol. M95, of Deeds on Page 19862.

Bernetha G. Letsch, County Clerk

FEE $10.00 By [signature]