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Vol. 95 Page 21197

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I.D. TAG NO.

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OREGON DEPARTMENT OF HUMAN RESOURCES
HEALTH DIVISION
CENTER FOR HEALTH STATISTICS 136-
CERTIFICATE OF DEATH

State File Number

1. DECEDENT'S NAME First: Mayme Middle: Estelle Last: MASON		2. SEX Female	3. DATE OF DEATH (Month, Day, Year) July 30, 1995
4. SOCIAL SECURITY NUMBER 569-22-2003		5a. AGE-Last Birthday (Years) 75	5b. Under 1 Year Mos. Days 75
5c. Under 1 Day Hours Mins. 75		6. BIRTHPLACE (City and State or Foreign) Vernon, Texas	
7. DATE OF BIRTH (Month, Day, Year) August 8, 1919			
8. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
9a. PLACE OF DEATH (Check only one) <input type="checkbox"/> Hospital <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> EROutpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <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) Business Owner		10b. KIND OF BUSINESS/INDUSTRY Dry Cleaner	
11. MARITAL STATUS - Married, Never Married, Widowed, Divorced (Specify) Married		12. SPOUSE (If Married, Widowed) James Yax	
13a. RESIDENCE - STATE Oregon		13b. CITY, TOWN OR LOCATION Klamath Falls	
13c. STREET AND NUMBER 4385 C Bartlett Avenue			
13d. INSIDE CITY LIMITS? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		13e. 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 (1-4 or 5+) 10			
17. FATHER - NAME first middle last Porter		18. MOTHER - NAME first middle maiden James Yax - Spouse	
19. INFORMANT - NAME and relationship to deceased James Yax - Spouse			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" 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 Crematory	
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) 3588	
22. NAME, ADDRESS AND ZIP OF FACILITY Eternal Hills Funeral Home 4711 Highway 39 Klamath Falls, OR. 97603			
23. DATE FILED (Month, Day, Year) AUG 02 1995		24. REGISTRAR'S SIGNATURE <i>[Signature]</i>	
25. DID HOSPITAL REPRESENTATIVE MAKE REQUEST FOR ANATOMICAL GIFT CONSENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> N/A		26. WAS GIFT MADE? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> N/A	
TO BE COMPLETED BY CERTIFYING PHYSICIAN			
27. TIME OF DEATH 12:25 p. M.		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> M.D.			
30. DATE SIGNED (Month, Day, Year) 8/1/95		31. DATE SIGNED (Month, Day, Year) COUNTY	
32. NAME, TITLE, ADDRESS AND ZIP OF CERTIFIER/MEDICAL EXAMINER (Type or Print) James F. Calvert M.D. 2800 Daggett Avenue Klamath Falls, Oregon 97601			
33. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)			
34. 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			
(a) HEPATIC FAILURE		Interval between onset and death	
(b) SEPSIS		Interval between onset and death	
(c) RENAL FAILURE		Interval between onset and death	
35. OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not resulting in the underlying cause given in PART I. HEPATIC FAILURE, COAGULOPATHY			
36. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Undetermined <input type="checkbox"/> Suicide <input type="checkbox"/> Legal Intervention <input type="checkbox"/> Homicide		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. DATE OF INJURY (Month, Day, Year)		39. AUTOPSY <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
40. TIME OF INJURY M		41. YES were findings considered in determining cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
41a. PLACE OF INJURY - At home, farm, street, factory, office building etc. (Specify)		41b. DESCRIBE HOW INJURY OCCURRED	
42. LOCATION (Street and Number or Rural Route Number, City or Town, State)			

RESERVED FOR REGISTRAR'S USE

Upon recording return to:
James Yax
4385 Bartlett Ave. #C
Klamath Falls, OR 97603

THIS IS A TRUE AND EXACT REPRODUCTION OF THE DOCUMENT OFFICIALLY
REGISTERED AT THE OFFICE OF OREGON VITAL RECORDS

DATE ISSUED:

AUG 02 1995

JANET BAILEY-GOBER
COUNTY REGISTRAR
KLAMATH COUNTY, OREGON

STATE OF OREGON: COUNTY OF KLAMATH: ss.

Filed for record at request of Mountain Title Co. the 9th day
of August A.D., 19 95 at 3:24 o'clock P M., and duly recorded in Vol. M95
of Deeds on Page 21197

Bernetha G. Letsch, County Clerk

By *[Signature]*

FEE \$10.00

Ret: Mountain Title Co