

4271

08-09-95P03:31 RCVD

Vol. 95 Page 21224

TYPE OR
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I.D. TAG NO.

197

Local File Number

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

136

State File Number

1. DECEDENT'S NAME First: Alexander Middle: SMITH Last: SMITH		2. SEX Male	3. DATE OF DEATH (Month, Day, Year) May 2, 1995																
4. SOCIAL SECURITY NUMBER 503-01-1803		5a. AGE-Last Birthday (Years) 90	5b. Under 1 Year Mo. Days Hours Mins																
6. BIRTHPLACE (City and State or Foreign Country) Bokoshe, Oklahoma		7. DATE OF BIRTH (Month, Day, Year) December 6, 1904																	
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 checked="" type="checkbox"/> HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA <input type="checkbox"/> OTHER <input checked="" 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) Plum Ridge Care 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) Carmen		10b. KIND OF BUSINESS/INDUSTRY railroad																	
11. MARITAL STATUS - Married Never Married, Widowed, Divorced (Specify) Married		12. SPOUSE (If Married, Widowed) Eda LaVern Smith																	
13a. RESIDENCE - STATE Oregon	13b. COUNTY Klamath	13c. CITY, TOWN OR LOCATION Klamath Falls																	
13d. INSIDE CITY LIMITS? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		13e. ZIP CODE 97603	13f. STREET AND NUMBER 2860 Homedale Road																
14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		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+) 8																
17. FATHER - NAME first middle last John - Smith		18. MOTHER - NAME first middle maiden Frances -- Moy																	
19. INFORMANT - NAME and relationship to decedent Eda LaVern Smith Spouse		20. LOCATION - City or Town, State Klamath Falls, Oregon																	
21a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH <i>Michael Ph</i>		21b. LICENSE NUMBER (Of Licensee) CO-3287	22. NAME, ADDRESS AND ZIP OF FACILITY O'Hair's Funeral Chapel 515 Pine ST. Klamath Falls, OR 97601																
23. DATE FILED (Month, Day, Year) MAY 04 1995		24. REGISTRAR'S SIGNATURE <i>Janet Bailey-Gober</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																	
<table border="1"> <tr> <td colspan="2">TO BE COMPLETED BY CERTIFYING PHYSICIAN</td> <td colspan="2">TO BE COMPLETED ONLY BY MEDICAL EXAMINER</td> </tr> <tr> <td>27. TIME OF DEATH 11:45 P.M.</td> <td>28. WAS MEDICAL EXAMINER NOTIFIED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</td> <td>31a. TIME OF DEATH M</td> <td>31b. DATE PRONOUNCED DEAD (Month, Day, Year, Hour) M</td> </tr> <tr> <td colspan="2">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>Sean Dow</i> M.D.</td> <td colspan="2">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)</td> </tr> <tr> <td colspan="2">30. DATE SIGNED (Month, Day, Year) May 3 1995</td> <td colspan="2">33. DATE SIGNED (Month, Day, Year) COUNTY</td> </tr> </table>				TO BE COMPLETED BY CERTIFYING PHYSICIAN		TO BE COMPLETED ONLY BY MEDICAL EXAMINER		27. TIME OF DEATH 11:45 P.M.	28. WAS MEDICAL EXAMINER NOTIFIED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	31a. TIME OF DEATH M	31b. DATE PRONOUNCED DEAD (Month, Day, Year, Hour) M	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>Sean Dow</i> M.D.		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)		30. DATE SIGNED (Month, Day, Year) May 3 1995		33. DATE SIGNED (Month, Day, Year) COUNTY	
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34. NAME, TITLE, ADDRESS AND ZIP OF CERTIFIER/MEDICAL EXAMINER (Type or Print) Sean Dow M.D. 2628 Campus Drive, Klamath Falls, Oregon 97601																			
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.)																			
PART I (a) <i>Alzheimer's</i>		Interval between onset and death																	
(b) DUE TO, OR AS A CONSEQUENCE OF:		Interval between onset and death																	
(c) <i>Parkinson's</i>		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.		37. Did tobacco use contribute to the death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																	
38. AUTOPSY <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		39. If YES were findings considered 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 <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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ORIGINAL VITAL STATISTICS COPY

DATE ISSUED:

MAY 04 1995

JANET BAILEY-GOBER
COUNTY REGISTRAR
KLAMATH COUNTY, OREGON

STATE OF OREGON: COUNTY OF KLAMATH: ss.

Filed for record at request of Keith Smith the 9th day of August A.D., 19 95 at 3:31 o'clock p M., and duly recorded in Vol. M95 of Deeds on Page 21224.

FEE \$10.00

Berntha G. Letsch, County Clerk

By *Janet Bailey-Gober*

Return to: Keith Smith, 803 Main #404, Klamath Falls, OR 97601