

CERTIFICATE OF INCUMBENCY OF TRUSTEE
JACQUELINE MILLER 1993 REVOCABLE TRUST
(Under Agreement dated September 24, 1995)

STATE OF OREGON, (County of Klamath) ss.

I, ROBERT SCOTT STARBUCK, being duly sworn, depose and say:

1. That the Jacqueline Miller 1993 Revocable Trust was established by an Agreement dated September 24, 1993, between Jacqueline (Lynn) Forman Miller as Trustor, and Jacqueline (Lynn) Forman Miller as Initial Trustee;

2. That the initial trustee, Jacqueline (Lynn) Forman Miller died on August 16, 1995. A certified copy of the Certificate of Death regarding Jacqueline (Lynn) Forman Miller, aka Jacqueline F. Starbuck Miller, is attached hereto and made a part hereof.

3. That the Trust Agreement contemplates that in the event of the death of the Initial Trustee, that Robert Scott Starbuck shall serve as Successor Trustee.

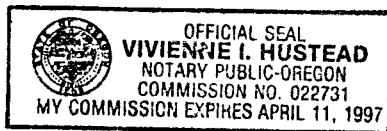
4. That Robert Scott Starbuck, as Successor Trustee, was not appointed by a Court and is not required to be appointed by a Court under Oregon law.

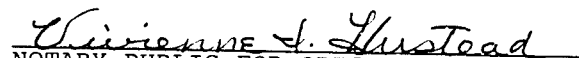
5. That by his signature below, Robert Scott Starbuck does hereby consent to serve as Successor Trustee of the Trust, accepting such position as Successor Trustee.

DATED: This 22 day of August, 1995.


ROBERT SCOTT STARBUCK

SUBSCRIBED AND SWORN to before me August 22, 1995.




NOTARY PUBLIC FOR OREGON
My Commission Expires: 4-11-97

After recording return to:

NEAL G. BUCHANAN
Attorney at Law
601 Main Street, Suite 215
Klamath Falls, OR 97601

NB/2 - CERTIFICATE OF INCUMBENCY - Solo

22828

TYPE OR
PRINT IN
PERMANENT
BLACK INK167907
I.D. TAG NO.
388OREGON DEPARTMENT OF HUMAN RESOURCES
HEALTH DIVISION
CENTER FOR HEALTH STATISTICS
CERTIFICATE OF DEATH

State File Number

Local File Number

1. DECEDENT'S NAME First: Jacqueline Middle: Forman Last: MILLER		2. SEX Female	3. DATE OF DEATH (Month, Day, Year) August 16 1995
4. SOCIAL SECURITY NUMBER 569-24-0339		5a. AGE-Last Birthday (Years) 69	5b. Under 1 Year Mos. Days Hours Mins.
6. BIRTHPLACE (City and State or Foreign Country) Lovell Wyoming		7. DATE OF BIRTH (Month, Day, Year) August 6 1926	
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	
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) Melvin Miller	
13a. RESIDENCE - STATE Oregon		13b. COUNTY Klamath	
13c. CITY, TOWN OR LOCATION Klamath Falls		13d. STREET AND NUMBER 4875 Sunset Ridge Road	
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. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		17. ZIP CODE 97601	
17. FATHER - NAME first middle last Henry - Forman		18. MOTHER - NAME first middle maiden Emma - Paulson	
19. INFORMANT - NAME and relationship to decedent Melvin Miller Husband		20. LOCATION - City or Town, State Klamath Falls, Oregon	
21a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH <i>Janet Bailey</i>		21b. LICENSE NUMBER (Of License) CO-3572	
22. DATE FILED (Month, Day, Year) AUG 21 1995		23. NAME, ADDRESS AND ZIP OF FACILITY O'Hairs Funeral Chapel 515 Pine Street Klamath Falls OR. 97601	
24. REGISTERAR'S SIGNATURE <i>Janet Bailey</i>		25. WAS GIFT MADE? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	
26. 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 1:17 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>Thomas E. Klump</i> M.D.			
30. DATE SIGNED (Month, Day, Year)			
31. NAME, TITLE, ADDRESS AND ZIP OF CERTIFYING MEDICAL EXAMINER (Type or Print) Thomas Klump M.D. 2600 Clover Street Klamath Falls, Oregon, 97601			
32. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)			
33. 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) HEMORRHAGE OF INTRACRANIAL METASTATIC MALIGNANT MEANOMA		Interval between onset and death 8 DAYS	
(b) N/A		Interval between onset and death	
(c) N/A		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 type="checkbox"/> Probably <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
38. AUTOPSY <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		39. H 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 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. PLACE OF INJURY - At home, farm, street, factory, office building etc. (Specify)		41e. DESCRIBE HOW INJURY OCCURRED	
41f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			

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REGISTERED AT THE OFFICE OF THE KLAMATH COUNTY REGISTRAR.

ORIGINAL VITAL STATISTICS COPY

DATE ISSUED: **AUG 21 1995***Janet Bailey*JANET BAILEY-GOBER
COUNTY REGISTRAR
KLAMATH COUNTY, OREGON

STATE OF OREGON: COUNTY OF KLAMATH: ss.

Filed for record at request of Neal Buchanan the 24th day
of Aug A.D., 19 95 at 11:41 o'clock A M., and duly recorded in Vol. M95
of Deeds on Page 22827

Bernetha G. Letsch, County Clerk

FEE \$15.00

By *Spittie*