OREGON HEALTH DIVISION
CENTER FOR HEALTH STATISTICS

5525

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158004 I.D. TAG NO.

544 Local File Number

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

94-025554 State File Number

1. DECEDENT'S NAME: First	Middle	Last	2. SEX
Virl	GENE	VARNEY	Male

3. DATE OF DEATH (Month, Day, Year): December 13, 1994

4. SOCIAL SECURITY NUMBER: 554-22-7203

5a. AGE-Last Birthday (Years): 69

5b. Under 1 Year: Mos. / Days

5c. Under 1 Day: Hours / Mins.

6. BIRTHPLACE (City and State or Foreign Country): Brookfield, MO.

7. DATE OF BIRTH (Month, Day, Year): February 8, 1925

8. WAS DECEDENT EVER IN U.S. ARMED FORCES? ☒ Yes ☐ No

9a. 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): 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.): Engineer

10b. KIND OF BUSINESS/INDUSTRY: Heavy Construction

11. MARITAL STATUS - Married, Never Married, Widowed, Divorced (Specify): Married

12. SPOUSE (If Married, Widowed): Ruth

13a. RESIDENCE - STATE: Oregon

13b. COUNTY: Klamath

13c. CITY, TOWN OR LOCATION: Klamath Falls

13d. STREET AND NUMBER: 1023 Main St.

13e. INSIDE CITY LIMITS? ☐ Yes ☐ No

13f. ZIP CODE: 97601

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): 8; College (1-4 or 5+):

17. FATHER - NAME first / middle / last: Leslie - Varney

18. MOTHER - NAME first / middle / maiden: Coral - Bartholome

19. INFORMANT - NAME and relationship to deceased: Ruth Varney - Wife

20a. METHOD OF DISPOSITION: ☐ Burial ☒ Cremation ☐ Removal from State ☐ Donation ☐ Mausoleum ☐ 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: Jim Lancaster

21b. LICENSE NUMBER (Of Licensee): 3224

22. NAME, ADDRESS AND ZIP OF FACILITY: Eternal Hills Funeral Home 4711 Hwy #39/ Klamath Falls, OR 9760[illegible]

23. DATE FILED (Month, Day, Year): DEC 14 1994

24. REGISTRAR'S SIGNATURE: Nancy Kennedy

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: 11:45 A M

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] MD

30. DATE SIGNED (Month, Day, Year): 12/13/94

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 Etges, MD - 1905 Main St. - Klamath Falls, OR. 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) End stage Renal Failure — Interval between onset and death:
DUE TO, OR AS A CONSEQUENCE OF:
(b) HTN — Interval between onset and death:
DUE TO, OR AS A CONSEQUENCE OF:
(c) Atherosclerotic Vessel Disease — 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? ☒ 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 Ooccurred

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

09-01-95P01:22 RCVD

AFTER RECORDING RETURN TO:
Donald R. Crane, Atty at Law
635 Main Street, Klamath Falls OR 97601

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 AUG 2 8 1995

EDWARD J. JOHNSON II
STATE REGISTRAR

STATE OF OREGON: COUNTY OF KLAMATH: ss.

Filed for record at request of Don Crane the 1st day of Sept A.D., 19 95 at 1:22 o'clock P M., and duly recorded in Vol. M95, of Deeds on Page 23728.

FEE $10.00

Bernetha G. Letsch, County Clerk
By [signature]