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417

Local File Number

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

State File Number

1. DECEDENT'S NAME First: <u>John</u> Middle: <u>Richard</u> Last: <u>BANKHEAD</u>			2. SEX <u>Male</u>	3. DATE OF DEATH (Month, Day, Year) <u>August 29, 1995</u>
4. SOCIAL SECURITY NUMBER <u>553-42-6540</u>		5a. AGE-Last Birthday (Years) <u>61</u>	5b. Under 1 Year Mos. <u> </u> Days <u> </u>	5c. Under 1 Day Hours <u> </u> Mins. <u> </u>
6. BIRTHPLACE (City and State or Foreign) <u>Pingree, Idaho</u>			7. DATE OF BIRTH (Month, Day, Year) <u>October 15, 1933</u>	
8. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
9a. PLACE OF DEATH (Check only one) <input checked="" type="checkbox"/> HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ERO/Outpatient <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) <u>Merle West Medical Center</u>			9c. CITY, TOWN, OR LOCATION OF DEATH <u>Klamath Falls</u>	
10a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <u>Ground Keeper</u>			10b. KIND OF BUSINESS/INDUSTRY <u>School District</u>	
11. MARITAL STATUS - Married, Never Married, Widowed, Divorced (Specify) <u>Married</u>			12. SPOUSE (If Married, Widowed, Divorced) (Specify) <u>Marilyn Bankhead</u>	
13a. RESIDENCE - STATE <u>Oregon</u>		13b. COUNTY <u>Klamath</u>	13c. CITY, TOWN OR LOCATION <u>Klamath Falls</u>	
13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		13e. ZIP CODE <u>97601</u>	13f. STREET AND NUMBER <u>1200 Montclair</u>	
14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> No <input type="checkbox"/> Yes			15. RACE American Indian, Black, White, etc. (Specify) <u>White</u>	
16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) College (1-4 or 5+) <u>12</u>				
17. FATHER - NAME first middle last <u>Edwin Leon Bankhead</u>			18. MOTHER - NAME first middle maiden <u>Ethel Pearl Johnson</u>	
19. INFORMANT - NAME and relationship to decedent <u>Dean Martin - Brother-in-Law</u>				
20a. METHOD OF DISPOSITION <input type="checkbox"/> Mausoleum <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) <u>Eternal Hills Crematory</u>	
21a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH <u>David A. Wilson</u>			21b. LICENSE NUMBER (Of Licensee) <u>3588</u>	
22. NAME, ADDRESS AND ZIP OF FACILITY <u>Eternal Hills Funeral Home</u> <u>4711 Highway 39 Klamath Falls, Oregon 97603</u>				
23. DATE FILED (Month, Day, Year) <u>AUG 31 1995</u>			24. REGISTRAR'S SIGNATURE <u>Janet Bailey-Gober</u>	
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 <u>2:15 P.M.</u>		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. <u>M.D.</u>				
30. DATE SIGNED (Month, Day, Year) <u>8/30/95</u>				
31. NAME, TITLE, ADDRESS AND ZIP OF CERTIFIER/MEDICAL EXAMINER (Type or Print) <u>Robert P. Beaman M.D. 2300 Clairmont Drive Klamath Falls, Oregon 97601</u>				
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) <u>Unknown natural cause</u>			Interval between onset and death <u>2 months</u>	
DUE TO, OR AS A CONSEQUENCE OF:				
(b) <u>Undifferentiated large cell lung cancer</u>			Interval between onset and death	
DUE TO, OR AS A CONSEQUENCE OF:				
(c)			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. <u>COPD, Marked Obesity, Recent DVT</u>			37. Did tobacco use contribute to the death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> Probably <input type="checkbox"/> No <input type="checkbox"/> Unknown	
38. AUTOPSY <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			39. If YES were findings consistent 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 <u>M</u>			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. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

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ORIGINAL VITAL STATISTICS COPY

DATE ISSUED: AUG 31 1995JANET BAILEY-GOBER
COUNTY REGISTRAR
KLAMATH COUNTY, OREGON

STATE OF OREGON: COUNTY OF KLAMATH: ss.

Filed for record at request of Marilyn Bankhead
of Sept A.D., 19 95 at 3:05 o'clock P M., and duly recorded in Vol. M95
of Deeds on Page 25036

FEE \$10.00

By Bernetha G. Letsch, County Clerk
Annette Mueller