

H-02412  
I.D. TAG NO.  
627  
Local File Number

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

Vol. M95 Page 29145

State File Number

10-25-95A11:48 RCVD

1. DECEDENT'S NAME David Lane PETZNIK		2. SEX M	3. DATE OF DEATH (Month, Day, Year) October 22, 1995
4. SOCIAL SECURITY NUMBER 570 48 5725		5a. AGE Last Birthday (Years) 59	5b. Under 1 Year Mos
5c. Under 1 Day Hours		5d. Under 1 Day Mins	6. BIRTHPLACE (City and State or Foreign Country) Albadena, California
7. DATE OF BIRTH (Month, Day, Year) March 15, 1936		8. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
9a. FACILITY NAME (If not institution, give street and number) St. Charles Medical Center		9b. PLACE OF DEATH (Check only one) <input checked="" type="checkbox"/> HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> 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)	
9c. CITY, TOWN, OR LOCATION OF DEATH Bend		9d. COUNTY OF DEATH Deschutes	
10a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Certified Lumber Grader		10b. KIND OF BUSINESS/INDUSTRY Lumber	
11. MARITAL STATUS - Married, Never Married, Widowed, Divorced (Specify) Married		12. SPOUSE (If Married, Widowed) Lorella	
13a. RESIDENCE - STATE Oregon		13b. COUNTY Klamath	
13c. CITY, TOWN OR LOCATION Gilchrist		13d. STREET AND NUMBER Highway 97 Petznick's Video	
13e. INSIDE CITY LIMITS? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		13f. ZIP CODE 97737	
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		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+) 4		17. FATHER - NAME first middle last Carl Petznick	
18. MOTHER - NAME first middle maiden Minnie D. Schultz		19. INFORMANT - NAME and relationship to deceased Lorella Petznick, wife	
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) Central Oregon Cremation Assoc.	
20c. LOCATION - City or Town, State Bend, Oregon		21a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH Walter E. Bili	
21b. LICENSE NUMBER (Of Licensee) 3571		22. NAME, ADDRESS AND ZIP OF FACILITY Niswonger-Reynolds Inc. 105 N.W. Irving, Bend, Oregon 97701	
23. DATE FILED (Month, Day, Year) October 23, 1995		24. REGISTRAR'S SIGNATURE Viki Y. St. John, Dep.	
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	
27. TIME OF DEATH 5:21 A. M. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		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) Keith W. Harless, MD		30. DATE SIGNED (Month, Day, Year) October 23, 1995	
31. NAME, TITLE, ADDRESS AND ZIP OF CERTIFIER/MEDICAL EXAMINER (Type or Print) Keith W. Harless, M.D. 1501 N.E. Medical Center Drive, Bend, Oregon 97701		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)		34. COUNTY	
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) Abdominal Sepsis DUE TO, OR AS A CONSEQUENCE OF		Interval between onset and death Hours	
(b) Atherosclerosis and Complications to Surgery DUE TO, OR AS A CONSEQUENCE OF		Interval between onset and death Days	
(c) OTHER SIGNIFICANT CONDITIONS - Coronary artery disease resulting in the underlying cause given in PART I. Ischemic Heart Disease Heatin Associated Thrombocytopenia		Interval between onset and death	
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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
39. If YES were findings considered in determining cause of death? <input checked="" 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"/> Homicide <input type="checkbox"/> Legal Intervention <input type="checkbox"/> Other	
41a. DATE OF INJURY (Month, Day, Year)		41b. TIME OF INJURY M <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
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)	

ORIGINAL-VITAL STATISTICS COPY

45-2 Rev 12/94

STATE OF OREGON, COUNTY OF DESCHUTES

I HEREBY CERTIFY THAT THE FOREGOING COPY HAS BEEN COMPARED BY ME WITH THE ORIGINAL DOCUMENT AND IS A TRUE, FULL, AND CORRECT COPY OF THE ORIGINAL CERTIFICATE AS THE SAME APPEARS ON FILE IN THE VITAL RECORDS UNIT OF THE DESCHUTES COUNTY HEALTH DEPARTMENT AND IN MY OFFICIAL CARE AND CUSTODY.

NOT VALID WITHOUT RAISED SEAL OF  
DESCHUTES COUNTY HEALTH DEPARTMENT

Viki Y. St. John, Deputy Registrar  
VIKI ST. JOHN, DEPUTY REGISTRAR

October 23, 1995  
DATE

Please return to: Niswonger-Reynolds Inc  
P.O. Box 229  
Bend, OR 97709

STATE OF OREGON: COUNTY OF KLAMATH: ss.

Filed for record at request of Niswonger- Reynolds, Inc the 25th day of October A.D., 19 95 at 11:48 o'clock A M., and duly recorded in Vol. M95 of Deeds on Page 29145

FEE \$10.00

Bernetha G. Letsch, County Clerk  
By Annette Mueller

10:00  
cc