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I.D. TAG NO.

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Local File Number

OREGON DEPARTMENT OF HUMAN RESOURCES
HEALTH DIVISION
CENTER FOR HEALTH STATISTICS
CERTIFICATE OF DEATH 138

State File Number

1. DECEDENT'S NAME First: <u>Mary</u> Middle: <u>-</u> Last: <u>MACOMBER</u>		2. SEX <u>Female</u>	3. DATE OF DEATH (Month, Day, Year) <u>November 15, 1995</u>
4. SOCIAL SECURITY NUMBER <u>464-40-1176</u>	5a. AGE-Last Birthday (Years) <u>85</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 Country) <u>Pennsylvania</u>		7. DATE OF BIRTH (Month, Day, Year) <u>February 1, 1910</u>	
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 type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Decedent's Home <input type="checkbox"/> Other (Specify)			
9b. FACILITY NAME (If not institution, give street and number) <u>6345 Simmers Lane</u>		9c. CITY, TOWN, OR LOCATION OF DEATH <u>Klamath Falls</u>	
9d. COUNTY OF DEATH <u>Klamath</u>			
10a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <u>Baker</u>		10b. KIND OF BUSINESS/INDUSTRY <u>Food</u>	
11. MARITAL STATUS - <u>Married</u> Never Married, Widowed, Divorced (Specify)		12. SPOUSE (If Married, Widowed) <u>Lester Macomber</u>	
13a. RESIDENCE - STATE <u>Oregon</u>	13b. COUNTY <u>Klamath</u>	13c. CITY, TOWN OR LOCATION <u>Klamath Falls</u>	13d. STREET AND NUMBER <u>6345 Simmers Lane</u>
13e. INSIDE CITY LIMITS? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	13f. ZIP CODE <u>97603</u>	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) <u>White</u>		16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <u>10</u> College (1-4 or 5+)	
17. FATHER - NAME first middle last <u>- - -</u>		18. MOTHER - NAME first middle maiden <u>Minnie -</u>	
19. INFORMANT - NAME and relationship to deceased <u>Lester Macomber - Spouse</u>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Mausoleum <input checked="" 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>[Signature]</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>NOV 17 1995</u>		24. REGISTRAR'S SIGNATURE <u>[Signature]</u>	
25. DID HOSPITAL REPRESENTATIVE MAKE REQUEST FOR ANATOMICAL GIFT CONSENT? <input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> N/A		26. WAS GIFT MADE? <input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> N/A	
TO BE COMPLETED BY CERTIFYING PHYSICIAN			
27. TIME OF DEATH <u>1:00 p.</u> 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) <u>[Signature]</u> M.D.			
30. DATE SIGNED (Month, Day, Year) <u>11/16/95</u>			
31. NAME, TITLE, ADDRESS AND ZIP OF CERTIFIER/MEDICAL EXAMINER (Type or Print) <u>R. Ron Hale M.D. 1000 Pine Street Klamath Falls, Oregon 97601</u>			
32. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)			
TO BE COMPLETED ONLY BY MEDICAL EXAMINER			
31a. TIME OF DEATH M <u>-</u>		31b. DATE PRONOUNCED DEAD (Month, Day, Year, Hour) M <u>-</u>	
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	
PART I 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)			
(a) <u>Cerebrovascular accident</u>		Interval between onset and death <u>13d</u>	
(b) <u>atherosclerosis</u>		Interval between onset and death <u>3yrs</u>	
(c)		Interval between onset and death	
PART II 37. OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not resulting in the underlying cause given in PART I <u>Senile dementia</u>			
38. 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"/> Manner <input type="checkbox"/> Homicide <input type="checkbox"/> Legal intervention		39. Did tobacco use contribute to the death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> Probably <input type="checkbox"/> No <input type="checkbox"/> Unknown	
40. DATE OF INJURY (Month, Day, Year)		41. AUTOPSY <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
41a. TIME OF INJURY M <u>-</u>		42. YES were findings consistent in determining cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> N/A	
41b. PLACE OF INJURY - At home, farm, street, factory, office, building, etc. (Specify)		41c. INJURY AT WORK? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
41d. DESCRIBE HOW INJURY OCCURRED		41e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

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ORIGINAL-VITAL STATISTICS COPY

NOV 17 1995

DATE ISSUED:

JANET BAILEY GORER
COUNTY REGISTRAR
KLAMATH COUNTY, OREGON

STATE OF OREGON: COUNTY OF KLAMATH: ss.

Filed for record at request of Lester Macomber the 27th day
of November A.D., 19 95 at 1:10 o'clock PM., and duly recorded in Vol. M95
of Deeds on Page 32245

FEE \$10.00

By Bernetha G. Letsch, County Clerk
Annette Mueller