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RCVD Vol. 195

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TYPE OR
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I.D. TAG NO.556
Local File NumberOREGON DEPARTMENT OF HUMAN RESOURCES
HEALTH DIVISION
CENTER FOR HEALTH STATISTICS 136-
CERTIFICATE OF DEATH

State File Number

DECEDENT

1

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3

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5

6

PARENTS

DISPOSITION

7

8

9

REGISTRAR

10

11

CERTIFIER

12

13

14

CONDITIONS

IF ANY

WHICH GAVE

RISE TO

IMMEDIATE

CAUSE

STATING THE

UNDERLYING

CAUSE LAST

CAUSE OF

DEATH

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1. DECEDENT'S NAME First: Elwyn Middle: Ernest Last: RICE		2. SEX Male	3. DATE OF DEATH (Month, Day, Year) November 19, 1995
4. SOCIAL SECURITY NUMBER 366-20-5563		5a. AGE-Last Birthday (Years) 71	5b. Under 1 Year Mo: Days: Hours: Mins:
6. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		7. DATE OF BIRTH (Month, Day, Year) November 10, 1924	
8. 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		9. BIRTHPLACE (City and State or Foreign Country) Rockford, MI	
10. FACILITY NAME (If not institution, give street and number) Merle West Medical Center		11. MARITAL STATUS - Married Never Married, Widowed, Divorced (Specify)	
12. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) Tail Sawyer		13. SPOUSE (If Married, Widowed) Betty R.	
14. DECEDENT'S KIND OF BUSINESS/INDUSTRY Weyco Timber		15. RACE American Indian, Black, White, etc. (Specify) White	
16. RESIDENCE - STATE Oregon		17. COUNTY Klamath	
18. CITY, TOWN, OR LOCATION OF DEATH Klamath Falls		19. STREET AND NUMBER 4762 Alva Street	
20. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		21. ZIP CODE 97603	
22. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		23. RACE American Indian, Black, White, etc. (Specify) White	
24. FATHER - NAME first middle last Clarence - Rice		25. MOTHER - NAME first middle maiden Erma - Turner	
26. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		27. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) Klamath Memorial Park	
28. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH <i>David C. Davenport</i>		29. LICENSE NUMBER (Of Licensee) FS-0124	
30. DATE FILED (Month, Day, Year) NOV 21 1995		31. NAME, ADDRESS AND ZIP OF FACILITY Davenport's Chapel of the Good Shepherd, 6420 So. 6th St., Klamath Falls, Oregon 97603-7194	
32. DID HOSPITAL REPRESENTATIVE MAKE REQUEST FOR ANATOMICAL GIFT CONSENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A		33. WAS GIFT MADE? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> N/A	
34. TIME OF DEATH 07:56 A M		35. DATE PRONOUNCED DEAD (Month, Day, Year, Hour) M	
36. TO THE BEST OF MY KNOWLEDGE, DEATH OCCURRED AT THE TIME, DATE, PLACE AND MANNER STATED. (Signature) <i>Charles L. Christensen</i>		37. DATE SIGNED (Month, Day, Year) November 20, 1995	
38. NAME, TITLE, ADDRESS AND ZIP OF CERTIFIER/MEDICAL EXAMINER (Type or Print) Charles L. Christensen, MD, 1900 Main Street, Klamath Falls, Oregon 97601		39. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)	
40. 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) AROXIC ENCEPHALOPATHY DUE TO, OR AS A CONSEQUENCE OF: (b) VENTRICULAR FIBRILLATION DUE TO, OR AS A CONSEQUENCE OF: (c) CORONARY ARTERY DISEASE PART II OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not resulting in the underlying cause given in PART I.		41. AUTO/PSY 37. Did tobacco use contribute to the death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown 38. AUTO/PSY 38. If YES were findings considered in determining cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> N/A	
42. 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		43. DATE OF INJURY (Month, Day, Year)	
44. TIME OF INJURY M		45. INJURY AT WORK? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
46. PLACE OF INJURY - At home, farm, street, factory, office building etc. (Specify)		47. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

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ORIGINAL VITAL STATISTICS COPY

DATE ISSUED: NOV 21 1995

Janet Bailey-Gober
JANET BAILEY-GOBER
COUNTY REGISTRAR
KLAMATH COUNTY, OREGON

STATE OF OREGON: COUNTY OF KLAMATH: ss.

Filed for record at request of _____ the 1st day
of December A.D., 19 95 at 3:31 o'clock P M., and duly recorded in Vol. M95
of Deeds on Page 32979.

FEE \$10.00

By Bernetha G. Letsch, County Clerk
Annette Mueller