CERTIFICATION OF VITAL RECORD

15204

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OREGON HEALTH DIVISION
CENTER FOR HEALTH STATISTICS

TYPE OR PRINT IN PERMANENT BLACK INK

140076 I.D. TAG NO.

108 Local File Number

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

136- 93-004653 State File Number

1 DECEDENT'S NAME: Dorothy Johnson MUSTOE
2 SEX: Female
3 DATE OF DEATH (Month, Day, Year): March 1, 1993
4 SOCIAL SECURITY NUMBER: 561-24-5213
5a AGE-Last Birthday (Years): 69
5b Under 1 Day (Months, Days, Hours, Minutes)
5c Under 1 Day
6 BIRTHPLACE (City and State or Foreign Country): Porterdale, Georgia
7 DATE OF BIRTH (Month, Day, Year): May 17, 1923
8 WAS DECEDENT EVER IN U.S. ARMED FORCES? ☐ Yes ☒ No
8a PLACE OF DEATH (Check only one): HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Decedent's Home ☐ Other (Specify)
8b FACILITY NAME (If not institution, give street and number): Clairmont Nursing Center
8c CITY, TOWN OR LOCATION OF DEATH: Klamath Falls
8d COUNTY OF DEATH: Klamath
9a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Welfare Worker
9b KIND OF BUSINESS/INDUSTRY: State Government
10 MARITAL STATUS - Married, Never Married, Widowed, Divorced (Specify): Married
12 SPOUSE (If married, widowed or divorced): Roy Mustoe
13a RESIDENCE - STATE: Oregon
13b COUNTY: Klamath
13c CITY, TOWN OR LOCATION: Klamath Falls
13d STREET AND NUMBER: 435 Oak Street
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
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+): ?
17 FATHER'S NAME (First, Middle, Last): Soule Leon Johnson
18 MOTHER'S NAME (First, Middle, Maiden): Lovey - Brooks
19 INFORMANT'S NAME and relationship to deceased: Dorothy Mustoe - Self
20a METHOD OF DISPOSITION: ☐ Burial ☒ Cremation ☐ Removal from State ☐ Donation ☐ 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: Carla A. Robinson
21b LICENSE NUMBER (Of Licensee): 93-49-1363
22 NAME, ADDRESS AND ZIP OF FACILITY: Eternal Hills Funeral Home 4711 Hwy. 39, Klamath Falls, OR 97603
23 DATE FILED (Month, Day, Year): MAR 0 8 1993
24 REGISTRAR'S SIGNATURE: Carla Robinson
25 DID HOSPITAL REPRESENTATIVE MAKE REQUEST FOR ANATOMICAL GIFT CONSIDERATION? ☐ YES ☐ NO ☒ N/A
26 WAS GIFT MADE? ☐ YES ☐ NO ☐ N/A

TO BE COMPLETED BY CERTIFYING PHYSICIAN

27 TIME OF DEATH: 3:55 P.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): Terrence A. Degan M.D.
30 DATE SIGNED (Month, Day, Year): 3-5-93

TO BE COMPLETED ONLY BY MEDICAL EXAMINER

31a TIME OF DEATH
31b DATE PRONOUNCED DEAD (Month, Day, Year)
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 CERTIFYING MEDICAL EXAMINER (Type or Print): Terence A. Degan M.D. 905 Main Street, Klamath Falls, Oregon 97601
35 NAME OF ATTENDING PHYSICIAN (If OTHER than Certifier) (Type or Print)

CONDITIONS IF ANY WHICH GAVE RISE TO IMMEDIATE CAUSE STATING THE UNDERLYING CAUSE LAST

CAUSE OF DEATH

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) LUNG CANCER — Interval between onset and death: 4 years
DUE TO OR AS A CONSEQUENCE OF
(b) — 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: Chronic Obstructive Lung Disease
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 ☐ Could not be determined ☐ Legal Intervention
41a DATE OF INJURY (Month, Day, Year)
41b TIME OF INJURY
41c INJURY AT WORK? ☐ Yes ☐ 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)

RESERVED FOR REGISTRAR'S USE

ORIGINAL — VITAL STATISTICS COPY

45-2 Rev 7/91

'96 MAR 22 P3:53

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 MAR 19 1996

EDWARD J. JOHNSON II
STATE REGISTRAR

STATE OF OREGON: COUNTY OF KLAMATH : ss.

Filed for record at request of Janice Joham the 22nd day of March A.D., 19 96 at 3:53 o'clock P M., and duly recorded in Vol. M96, of Deeds on Page 7995.

FEE $10.00

Returr Ret: Janice Joham
1660 Sleepy Hollow
Grants Pass,OR 97527

Bernetha G. Letsch, County Clerk
By