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15205

OREGON HEALTH DIVISION
CENTER FOR HEALTH STATISTICS

'96 MAR 22 P3:53

G-4095 I.D. TAG NO. 480 Local File Number

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

95-020591 State File Number

1. DECEDENT'S NAME First	Middle	Last	2. SEX	3. DATE OF DEATH (Month, Day, Year)
Roy	Ward	MUSTOE	Male	October 2, 1995

4. SOCIAL SECURITY NUMBER	5a. AGE-Last Birthday (Years)	5b. Under 1 Year Mos. / Days	5c. Under 1 Day Hours / Mins.	6. BIRTHPLACE (City and State or Foreign Country)	7. DATE OF BIRTH (Month, Day, Year)
571-03-7812	76			Klamath Falls, OR	August 3, 1919

8. WAS DECEDENT EVER IN U.S. ARMED FORCES? ☒ Yes ☐ No

9a. PLACE OF DEATH (Check only one): HOSPITAL ☐ Inpatient ☒ ER/Outpatient ☐ DOA | OTHER ☐ Nursing Home ☐ Decedent's Home ☐ Other (Specify)

9b. FACILITY NAME (If not institution, give street and number)	9c. CITY, TOWN, OR LOCATION OF DEATH	9d. COUNTY OF DEATH
Merle West Medical Center	Klamath Falls	Klamath

10a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.)	10b. KIND OF BUSINESS/INDUSTRY	11. MARITAL STATUS - Married, Never Married, Widowed, Divorced (Specify)	12. SPOUSE (If Married, Widowed)
Millworker	Lumber Mill	Widowed	Dorothy

13a. RESIDENCE - STATE	13b. COUNTY	13c. CITY, TOWN OR LOCATION	13d. STREET AND NUMBER
Oregon	Klamath	Klamath Falls	435 Oak St.

13e. INSIDE CITY LIMITS?	13f. ZIP CODE	14. WAS DECEDENT OF HISPANO ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.)	15. RACE American Indian, Black, White, etc. (Specify)	16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	College (1-4 or 5+)
☒ Yes ☐ No	97601	☐ No ☐ Yes Specify:	White	12	

17. FATHER - NAME first middle last	18. MOTHER - NAME first middle maiden	19. INFORMANT - NAME and relationship to deceased
George - Mustoe	Bonita - Ward	Janice Joham - daughter

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	20c. LOCATION - City or Town, State
☐ Burial ☒ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)	Klamath Cremation Service	Klamath Falls, Oregon

21a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH	21b. LICENSE NUMBER (Or Licensee)	22. NAME, ADDRESS AND ZIP OF FACILITY
[signature]	0329	Ward's Klamath Funeral Home, Inc. 1945 Main, Klamath Falls, OR 97601

23. DATE RECEIVED BY REGISTRAR (Month, Day, Year): OCT 05 1995

24. REGISTRAR'S SIGNATURE: [signature]

25. DID HOSPITAL REPRESENTATIVE MAKE REQUEST FOR ANATOMICAL GIFT CONSENT? ☒ YES ☐ NO ☐ N/A

26. WAS GIFT MADE? ☒ YES ☐ NO ☐ N/A

TO BE COMPLETED BY CERTIFYING PHYSICIAN

27. TIME OF DEATH: 2320 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): [signature]

30. DATE SIGNED (Month, Day, Year): 10-5-95

TO BE COMPLETED ONLY BY MEDICAL EXAMINER

31a. TIME OF DEATH M

31b. DATE PRONOUNCED DEAD (Month, Day, Year, Hour) M

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 CERTIFIER/MEDICAL EXAMINER (Type or Print): Kenneth K. Magee, MD 1900 Main St, Klamath Falls, OR 97601

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

		Interval between onset and death
PART I (a)	Acute Myocardial Infarction	2-3 hrs
(b) DUE TO, OR AS A CONSEQUENCE OF:	Arteriosclerotic Heart Disease	yrs
(c) DUE TO, OR AS A CONSEQUENCE OF:		

PART II OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not resulting in the underlying cause given in PART I.: Diabetes Mellitus

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	41a. DATE OF INJURY (Month, Day, Year)	41b. TIME OF INJURY	41c. INJURY AT WORK?	41d. DESCRIBE HOW INJURY OCCURRED
☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Undetermined Manner ☐ Legal Intervention		M	☐ Yes ☒ No	

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

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 Dorothy Mustoe 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 7996.

Bernetha G. Letsch, County Clerk

By [signature]

FEE $10.00

Return: Janice Joham
1660 Sleepy Hollow
Grants Pass, OR 97527