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Vol. M96 Page 10648

194750
I.D. TAG NO.

149

Local File Number

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

136-

State File Number

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CERTIFIER

CONDITIONS
IF ANY
WHICH GAVE
RISE TO
IMMEDIATE
CAUSE
STATING THE
UNDERLYING
CAUSE LASTCAUSE OF
DEATH15
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1. DECEDENT'S NAME First: Arthur Middle: Purcell Last: HAGAN			2. SEX Male	3. DATE OF DEATH (Month, Day, Year) March 30, 1996
4. SOCIAL SECURITY NUMBER 517-03-6131		5a. AGE-Last Birthday (Years) 84	5b. Under 1 Year Mos. Days	5c. Under 1 Day Hours Mins.
6. BIRTHPLACE (City and State or Foreign Country) Clarksville, MN		7. DATE OF BIRTH (Month, Day, Year) April 22, 1911		
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 checked="" type="checkbox"/> Hospital <input type="checkbox"/> Impatient <input type="checkbox"/> EMO 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)				
9b. FACILITY NAME (If not institution, give street and number) Merle West Medical Center				
9c. CITY, TOWN, OR LOCATION OF DEATH Klamath Falls				
9d. COUNTY OF DEATH Klamath				
10a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) Civil Service		10b. KIND OF BUSINESS/INDUSTRY U.S. Air Force		
11a. RESIDENCE - STATE Oregon		11b. CITY, TOWN OR LOCATION Klamath Falls		
11c. ZIP CODE 97603		11d. STREET AND NUMBER 3105 Altamont Drive		
12. INSIDE CITY LIMITS? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		13. 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		
14. FATHER - NAME first middle last Martin V. Hagan		15. MOTHER - NAME first middle maiden Isabel Isacs		
16. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		17. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) Eternal Hills Crematory		
18. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH <i>Wendy Hagan</i>		19. LICENSE NUMBER (Of Licensee) AE - 2778		
20. DATE FILED (Month, Day, Year) APR 01 1996		21. NAME, ADDRESS AND ZIP OF FACILITY Eternal Hills Funeral Home 4711 HWY 39 Klamath Falls, OR 97603		
22. DID HOSPITAL REPRESENTATIVE MAKE REQUEST FOR ANATOMICAL GIFT CONSENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> N/A		23. WAS GIFT MADE? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> N/A		
24. INFORMANT - NAME and relationship to deceased Phyllis Hagan - Spouse				
25. LOCATION - City or Town, State				
26. TO BE COMPLETED BY CERTIFYING PHYSICIAN				
27. TIME OF DEATH 1020 A M <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
28. TO THE BEST OF MY KNOWLEDGE, DEATH OCCURRED AT THE TIME, DATE, PLACE AND DUE TO THE CAUSES AND MANNER STATED (Signature) <i>W. B. Baker</i> M.D.				
29. DATE SIGNED (Month, Day, Year) 4/1/96				
30. NAME, TITLE, ADDRESS AND ZIP OF CERTIFIER/MEDICAL EXAMINER (Type or Print) William B. Baker, M.D. 2600 Campus Drive Klamath Falls, Oregon 97601				
31. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)				
32. 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) 2nd stage ischemic heart failure				
b) Severe coronary atherosclerosis				
c) OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not resulting in the underlying cause given in PART I				
33. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Undetermined Manner <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Legal Intervention <input type="checkbox"/> Other				
34a. DATE OF INJURY (Month, Day, Year)		34b. TIME OF INJURY		34c. INJURY AT WORK? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
34d. PLACE OF INJURY - At home, farm, street, factory, office, building etc. (Specify)		34e. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
35. Did tobacco use contribute to the death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
36. AUTOPSY <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
37. If YES were findings considered in determining cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> N/A				
38. DESCRIBE HOW INJURY OCCURRED				

THIS IS A TRUE AND EXACT REPRODUCTION OF THE DOCUMENT OFFICIALLY REGISTERED AT THE OFFICE OF THE KLAMATH COUNTY REGISTRAR.

DATE ISSUED: APR 01 1996

MARLENE BLEVINS
COUNTY REGISTRAR
KLAMATH COUNTY, OREGON

STATE OF OREGON: COUNTY OF KLAMATH: ss.

Filed for record at request of Phyllis Hagan
of April A.D., 19 96 at 9:50 o'clock AM., and duly recorded in Vol. M96
of Deeds on Page 10648

FEE \$10.00

Return: Phyllis Hagan
3105 Altamont Drive
Klamath Falls, Oregon 97603By Bernetha G. Letcher, County Clerk