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269

Local File Number

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

136-

State File Number

1. DECEDENT'S NAME First: Ted Middle: - Last: NEWMAN		2. SEX Male	3. DATE OF DEATH (Month, Day, Year) June 7, 1995
4. SOCIAL SECURITY NUMBER 553-05-7816	5a. Age Last Birthday (Years) 74	5b. Under 1 Year Mos. Days Hours Mins.	6. BIRTHPLACE (City and State or Foreign Country) McCleary, WA.
7. DATE OF BIRTH (Month, Day, Year) June 30, 1920		8. PLACE OF DEATH (Check only one) <input checked="" type="checkbox"/> HOSPITAL <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> 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)	
9a. FACILITY NAME (If not institution, give street and number) Marle West Medical Center		9b. CITY, TOWN, OR LOCATION OF DEATH Klamath Falls	
10a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) Mechanic		10b. KIND OF BUSINESS/INDUSTRY Diesel Trucks	
11. MARITAL STATUS - Married, Never Married, Widowed, Divorced (Specify) Married		12. SPOUSE (If Married, Widowed) Thelma Newman	
13a. RESIDENCE - STATE Oregon	13b. COUNTY Klamath	13c. CITY, TOWN OR LOCATION Klamath Falls	13d. STREET AND NUMBER 1233 Ward Street
14. RACE (Specify if other than White, Black, or Asian) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No White	15. HIGHEST GRADE COMPLETED (Specify only highest grade completed) 10	16. EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) College (1-4 or 5+)	
17. FATHER - NAME first middle last Con Cornilius Newman		18. MOTHER - NAME first middle maiden Thora - Norman	
19. INFORMANT - NAME and relationship to decedent Deborah Newman - Daughter		20. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) Eternal Hills Crematory	
21. METHOD OF DISPOSITION <input type="checkbox"/> Mausoleum <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Eternal Hills Crematory		22. NAME, ADDRESS AND ZIP OF FACILITY Eternal Hills Funeral Home 4711 Highway 30 Klamath Falls, Oregon 97603	
23. DATE FILED (Month, Day, Year) JUN 12 1995		24. REGISTRAR'S SIGNATURE Lucy L. Johnson	
25. DID HOSPITAL REPRESENTATIVE MAKE REQUEST FOR ANATOMICAL GIFT CONSENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> N/A		26. WAS GIFT MADE? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> N/A	
27. TIME OF DEATH 4:54 p.m.			
28. WAS MEDICAL EXAMINER NOTIFIED? <input checked="" type="checkbox"/> Yes <input 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) M.D.			
30. DATE SIGNED (Month, Day, Year) 6/14/95			
31. NAME, TITLE, ADDRESS AND ZIP OF CERTIFYING MEDICAL EXAMINER (Type or Print) Jon G. McKellar M.D. 2300 Clairmont Drive Klamath Falls, Oregon 97601			
32. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)			
33. 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 (a) DUE TO, OR AS A CONSEQUENCE OF: Thrombotic Cardiovascular Disease		Interval between onset and death	
PART (b) DUE TO, OR AS A CONSEQUENCE OF:		Interval between onset and death	
PART (c) OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not resulting in the underlying cause given in PART I.		Interval between onset and death	
34. 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"/> Legal Intervention <input type="checkbox"/> Homicide		35. DATE OF INJURY (Month, Day, Year)	
36. TIME OF INJURY		37. INJURY AT WORK? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
38. PLACE OF INJURY - At home, farm, street, factory, office building etc. (Specify)		39. DESCRIBE HOW INJURY OCCURRED	
40. Did tobacco use contribute to the death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		41. AUTOPSY <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
42. If YES were findings considered in determining cause of death?		43. If YES were findings considered in determining cause of death?	

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ONLY
Janet Bailey-Gober
COUNTY REGISTRAR
KLAMATH COUNTY, OREGON

DATE ISSUED: JUN 15 1995

STATE OF OREGON: COUNTY OF KLAMATH : \$15.

Filed for record at request of **AmeriTitle** the **24th** day
of **May** A.D., 19 **96** at **3:50** o'clock **P** M., and duly recorded in Vol. **M96**
of **Deeds** on Page **15219**

FEE \$10.00

By **Bernetha G. Letsch, County Clerk**