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OREGON HEALTH DIVISION
CENTER FOR HEALTH STATISTICS

TYPE OR PRINT IN PERMANENT BLACK INK

079759 I.D. TAG NO.
222 Local File Number

OREGON DEPARTMENT OF HUMAN RESOURCES
HEALTH DIVISION
Vital Records Unit
CERTIFICATE OF DEATH

136- 90 011025 State File Number

1 DECEDENT'S NAME: First	Middle	Last	2 SEX	3 DATE OF DEATH (Month, Day, Year)	
Marcia	Elaine	DOBRY	F	June 4, 1990	
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)
540-50-0364	47			Klamath Falls, OR	November 29, 1942

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)
Medical Technologist	Medical	Married	Len A. Dobry, D.M.D.

13a RESIDENCE - STATE	13b COUNTY	13c CITY, TOWN, OR LOCATION	13d STREET AND NUMBER	
Oregon	Klamath	Klamath Falls	8650 Hill Road	
13e INSIDE CITY LIMITS? ☐ Yes ☒ No	13f ZIP CODE 97603	14 WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.) ☒ No ☐ Yes Specify	15 RACE - American Indian, Black, White, etc. (Specify) White	16 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+)

17 FATHER - NAME first middle last	18 MOTHER - NAME first middle maiden	19 INFORMANT - NAME and relationship to deceased
Charles Elmont Kenyon	Hazel B. Cushman	Len A. Dobry, D.M.D. husband

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

21a SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH	21b LICENSE NUMBER (Of Licensee) 3287	22 NAME, ADDRESS AND ZIP OF FACILITY O'Hair's Funeral Chapel, Inc. 515 Pine St., Klamath Falls, OR 97601

23 DATE FILED (Month, Day, Year) JUN 4 1990

24 REGISTRAR'S SIGNATURE Nancy Kennedy

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: 1:50 A. 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 causes and manner stated. (Signature) Thomas E. Klumpp M.D.

30 DATE SIGNED (Month, Day, Year) June 4, 1990

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 CERTIFYING MEDICAL EXAMINER (Type or Print)
Thomas Klump, M.D., 2600 Clover Street, Klamath Falls, Oregon 97601

35 NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)

CONDITIONS IF ANY WHICH GIVE RISE TO IMMEDIATE CAUSE (A) 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) INTRACRANIAL HEMORRHAGE. — Interval between onset and death: 12 HRS.
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 related to cause given in PART I

37 Did tobacco use contribute to the death? ☐ Yes ☒ No ☐ Probably ☐ Unk	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 Manner ☐ Legal Intervention	41a DATE OF INJURY (Month, Day, Year)	41b TIME OF INJURY M	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. 1-88

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: APR 11 1996

EDWARD J. JOHNSON II
STATE REGISTRAR

STATE OF OREGON: COUNTY OF KLAMATH : ss.

Filed for record at request of AmeriTitle the 29th day of May A.D., 19 96 at 11:26 o'clock A M., and duly recorded in Vol. M96, of Deeds on Page 15468.

FEE $10.00

Return: Len Dobry
8650 Hill Road
Klamath Falls, Oregon 97603

Bernetha G. Letsch, County Clerk
By

96 MAY 29 A11:26