

SATISFACTION OF MORTGAGE

KNOW ALL MEN BY THESE PRESENTS, That _____

owner and holder of the Mortgage and the obligation hereinafter described, do hereby certify and declare that a certain mortgage, bearing date the 20th day of April, 1973, made and executed by Leon R. Palmer and Sally E. Palmer, husband and wife, the mortgagor therein to, A. Palmer and Virginia M. Palmer, the mortgagee therein, and recorded in the office of the Klamath County Clerk, State of Oregon, in Volume M73, Page 5110, Microfilm Records of Klamath County, Oregon, on April 30, 1973.

together with the debt thereby secured, is fully paid, satisfied, and discharged.

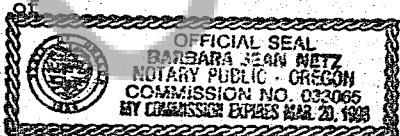
In construing this satisfaction of mortgage, where the context so required, singular includes the plural and all grammatical changes shall be implied to make the provisions hereof apply equally to corporation and to individuals.

IN WITNESS WHEREOF, the undersigned has executed this instrument this _____ day of _____, 19____; if the undersigned is a corporation it has caused its name to be signed _____

James M Palmer

STATE OF OREGON, County of Multnomah) ss.
This instrument was acknowledged before me on 5-31, 1996
by JAMES M PALMER
This instrument was acknowledged before me on _____, 19____

by
as
of



Barbara Jean Netz
Notary Public of Oregon
My commission expires 3-20-98

Mortgagee: James M Palmer

STATE OF OREGON, }
County of Klamath } ss

I certify that the within instrument was received for record on the 14th day of June, 1996, at 2:52 o'clock P M, and recorded in Volume No. M96 on page 17850 or as /instrument/ No. 19907, Record of Mortgages of said County.

Mortgagor: _____

Witness by my hand and seal of County affixed

AFTER RECORDING RETURN TO:

Ameritide

Bernetha G. Letsch, Co Clerk
NAME TITLE
By Synetha Heitz Deputy

FEE: \$10.00

**OREGON HEALTH DIVISION
CENTER FOR HEALTH STATISTICS**

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

95-012014

167983
LD TAG NO

Local File Number

State File Number

1. DECEDENT'S FIRST NAME Nelle		Middle M.		Last ALVAREZ		2. SEX Female	3. DATE OF DEATH (Month, Day, Year) June 2, 1995	
4. SOCIAL SECURITY NUMBER 581-28-8383		5a. AGE Last Birthday 74	5b. Under 1 Year Mons. Days	5c. Under 1 Day Hours Mins	6. BIRTHPLACE (City and State or Foreign) Guadalupe, Mexico		7. DATE OF BIRTH (Month, Day, Year) December 7, 1910	
8. WAS DECEDENT EVER IN U.S. ARMY FORECAST <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		9. PLACE OF DEATH (Check only one) <input 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)		10. FACILITY NAME (If not institution, give street and number) Merle West Medical Center				11. COUNTY OF DEATH Klamath
12. DECEDENT'S USUAL OCCUPATION (Do not use retired) Laundry Presser		13. KIND OF BUSINESS/INDUSTRY Laundry Industry		14. MARITAL STATUS - Married, Never Married, Widowed, Divorced (Specify) Widowed		15. SPOUSE (If Married, Widowed) Severino Pancho Alvarez		
16. RESIDENCE - STATE Oregon		17. COUNTY Klamath		18. CITY, TOWN OR LOCATION Klamath Falls		19. STREET AND NUMBER 4537 Winter Avenue		
20. INSIDE CITY LIMITS <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		21. ZIP CODE 97603		22. 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 Mexican		23. RACE American Indian, Black, White, etc. (Specify) Hispanic		
24. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (10-12) College (14 or 15+)		25. FATHER - NAME first middle last Carlos Morales		26. MOTHER - NAME first middle maiden Pomposa Torres		27. INFORMANT - NAME and relationship to decedent Teresa Herrera Daughter		
28. METHOD OF DISPOSITION <input type="checkbox"/> Mausoleum <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		29. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) Mt. Calvary Cemetery		30. LOCATION - City or Town, State Klamath Falls, Oregon				
31. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH <i>James O. Riggs</i>		32. LICENSE NUMBER CO-3572		33. NAME, ADDRESS AND ZIP OF FACILITY O'Hair's Funeral Chapel 515 Pine ST. Klamath Falls, OR 97601				
34. DATE FILED (Month, Day, Year) JUN 05 1995		35. DID HOSPITAL REPRESENTATIVE MAKE REQUEST FOR ANATOMICAL GIFT CONSENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> N/A		36. YAS GIFT MADE? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> N/A				
<p align="center">TO BE COMPLETED BY CERTIFYING PHYSICIAN</p> <p>37. TIME OF DEATH 8:50 A.M.</p> <p>38. WAS MEDICAL EXAMINER NOTIFIED? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>39. On the basis of my knowledge, death occurred at the time, date, place and due to the cause(s) and manner stated. (Signature) <i>Randal A. Machado</i> M.D.</p> <p>40. DATE SIGNED (Month, Day, Year) 6/2/95</p> <p>41. NAME, TITLE, ADDRESS AND ZIP OF CERTIFYING MEDICAL EXAMINER (Type or Print) Randal A. Machado M.D. 1905 Main Street Klamath Falls, Oregon 97601</p> <p>42. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)</p>								
<p align="center">TO BE COMPLETED ONLY BY MEDICAL EXAMINER</p> <p>43. TIME OF DEATH 8:50 A.M.</p> <p>44. DATE PRONOUNCED DEAD (Month, Day, Year, Hour) 6/2/95</p> <p>45. 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) <i>Edward J. Johnson</i></p> <p>46. DATE SIGNED (Month, Day, Year) 6/2/95</p> <p>47. COUNTY Klamath</p>								
<p>48. 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.)</p> <p>PART I</p> <p>(a) Unclear natural cause 1. KIDNEY Myocardial Infarction</p> <p>(b) Coronary artery disease</p> <p>(c) Hypertension</p> <p>PART II</p> <p>OTHER SIGNIFICANT CONDITIONS Conditions contributing to death but not resulting in the underlying cause given in PART I</p> <p>49. Did tobacco use contribute to the death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>50. AUTOPSY <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>51. If YES were findings considered a determining cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> N/A</p>								
52. MANNER OF DEATH <input 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		53a. DATE OF INJURY (Month, Day, Year)		53b. TIME OF INJURY M. P.		53c. INJURY AT WORK? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
54. PLACE OF INJURY - At home, farm, street, factory, office, building, etc. (Specify)		55. LOCATION (Street and Number or Rural Route Number, City or Town, State)						

RESERVED FOR REGISTRAR'S USE

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:

JUN 10 1995

EDWARD J. JOHNSON II
STATE REGISTRAR

STATE OF OREGON: COUNTY OF KLAMATH: 65.

Filed for record at request of AmeriTitle the 14th day of June A.D., 19 96 at 2:52 o'clock P M., and duly recorded in Vol. M96 of Deeds on Page 17851

FEE \$10.00

RETURN: Marvin Dunster
704 Miles Ave
Billings MT

59101

By Bernetha G. Leach, County Clerk